



<b>DENTAL HISTORY (CONTINUED)</b>	<input type="checkbox"/> Bleeding Gums?
Do you place a high priority on keeping your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bad breath (and/or) <input type="checkbox"/> Unpleasant tastes in your mouth
Do you have an electric tooth brush? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Tooth Sensitivity ( <input type="checkbox"/> hot <input type="checkbox"/> cold <input type="checkbox"/> sweets <input type="checkbox"/> chewing)	<b>JAW JOINT CONDITION</b>
<input type="checkbox"/> Fever Blisters (Cold Sores) (How many-_____ per year)	<input type="checkbox"/> History of TMD (jaw joint) problems
<input type="checkbox"/> Mouth Ulcers (Canker Sores) (How many-_____ per year)	<input type="checkbox"/> History of TMD (jaw joint) therapy performed
<input type="checkbox"/> Suck your finger/thumb/lip ( <input type="checkbox"/> now <input type="checkbox"/> past)	<input type="checkbox"/> Pain ( <input type="checkbox"/> popping <input type="checkbox"/> catching <input type="checkbox"/> locking of jaw joints)
<input type="checkbox"/> Tongue thrusting habit	<input type="checkbox"/> Clenching (and/or) <input type="checkbox"/> Grinding of teeth
<input type="checkbox"/> Gag easily	<input type="checkbox"/> wake up with sore jaw muscles
<input type="checkbox"/> Difficulty getting numbed with anesthetic	<input type="checkbox"/> Frequent Headaches (_____ per day / week / month)
<input type="checkbox"/> Brush your teeth (how often)	<input type="checkbox"/> Ear problems ( <input type="checkbox"/> dizziness <input type="checkbox"/> ringing <input type="checkbox"/> ear aches)
<input type="checkbox"/> Floss your teeth (how often)	<input type="checkbox"/> Tenderness/stiffness in the <input type="checkbox"/> jaw <input type="checkbox"/> neck <input type="checkbox"/> back
Please elaborate if necessary:	

<b>MEDICAL HISTORY</b>	<input type="checkbox"/> Bleeding Disorders / Anemia
<input type="checkbox"/> NO known drug allergies	<input type="checkbox"/> Subject to Prolonged Bleeding (and/or) <input type="checkbox"/> Bruise Easily
<input type="checkbox"/> YES drug allergies/intolerance. Please list:	<input type="checkbox"/> Gastrointestinal ( <input type="checkbox"/> Ulcers <input type="checkbox"/> Stomach problems <input type="checkbox"/> Other)
	<input type="checkbox"/> Diabetes ( <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Non Insulin Dependant)
<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Arthritis ( <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteoarthritis )
<input type="checkbox"/> Other allergies. Please list:	<input type="checkbox"/> Kidney (and/or) <input type="checkbox"/> Bladder Disease
List all current: medications:	<input type="checkbox"/> Thyroid trouble ( <input type="checkbox"/> Hyperactive <input type="checkbox"/> Hypoactive <input type="checkbox"/> Removed <input type="checkbox"/> Other
	<input type="checkbox"/> Cancer (type, date, treatment)
	<input type="checkbox"/> Radiation therapy (head/neck) <input type="checkbox"/> Surgery (head/neck) Date [s]:
List all previous surgeries or hospitalizations:	<input type="checkbox"/> Contact lens user
	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Do you premedicate with antibiotics before dental treatment?	<input type="checkbox"/> Neurological Problems ( <input type="checkbox"/> Epilepsy <input type="checkbox"/> Convulsions <input type="checkbox"/> Seizures)
<input type="checkbox"/> Rheumatic Fever (and/or) <input type="checkbox"/> Rheumatic Heart Disease	<input type="checkbox"/> Psychiatric Therapy (and/or) <input type="checkbox"/> Emotional problems
<input type="checkbox"/> Heart trouble (and/or) <input type="checkbox"/> Heart murmur (and/or) <input type="checkbox"/> Mitral valve Prolapse	<input type="checkbox"/> Tested for blood disease
<input type="checkbox"/> Prosthetic Devices ( <input type="checkbox"/> Pacemaker <input type="checkbox"/> Hip <input type="checkbox"/> Pins/Plates/Screws <input type="checkbox"/> Heart Valve <input type="checkbox"/> Other	<input type="checkbox"/> Have HIV/AIDS
	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Connective Tissue Disease
<input type="checkbox"/> Chest Pains (and/or) <input type="checkbox"/> Heart Attack (and/or) <input type="checkbox"/> By-pass surgery	<input type="checkbox"/> Pregnant <input type="checkbox"/> Possibly pregnant <input type="checkbox"/> Nursing
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Taking birth control pills
<input type="checkbox"/> Take Coumadin or any other blood thinners	<input type="checkbox"/> Serious illnesses not listed (list type, year):
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Lung Conditions ( <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Bronchitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other)	<b>SOCIAL HISTORY</b>
<input type="checkbox"/> Hay fever/Seasonal allergies <input type="checkbox"/> Other	Drink: <input type="checkbox"/> Coffee <input type="checkbox"/> Soda <input type="checkbox"/> Tea (____ Cup , ____ Cans or ____ glasses per day)
<input type="checkbox"/> Sinus Problems (how often)	<input type="checkbox"/> Currently use tobacco products (list quantity/frequency)
<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Cigarettes _____ <input type="checkbox"/> Cigars _____ <input type="checkbox"/> Smokeless
<input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Consume alcoholic beverages (How much-_____ per day/ week/ year)
Other/Please expand if needed:	

I authorize the doctor or other dentists or health-care professional (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care. I authorize release of any information concerning my (or my child's) health care for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care for advice and treatment to interdisciplinary team members. I consent to the release of credit reports and information regarding my credit history to the doctor(s). I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment, and to the use of the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature.

**The above information is accurate and complete to the best of my knowledge:**

Patient or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_