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Please give us some information about your health

Patient name:_____ Date:_____

Date of Birth:_____ Date of last dental exam:_____

Name and address of previous dentist:_____

Purpose for this visit:_____

If you have any of the following - indicate with a (√)

_ Teeth sensitive to cold, heat, sweets or pressure
_ Bleeding gums, how long:
_ Food impaction
_ Burning tongue feeling
_ Swelling or lumps in mouth
_ Frequent blisters on lips or mouth
_ Pain around ear(s)
_ Popping or noises in ear(s) while eating
_ Oral habits, i.e. fingernail biting or cheek biting
_ Unpleasant taste
_ Unfavorable dental experience
_ Complications from extractions
_ Periodontal treatment
_ Orthodontic treatment, if yes how long ago?_____
_ Mouth breathing
_ Bad breath

Are you happy with your smile?____ If not why?_____

If you have had orthodontics, who was your orthodontist and year completed?_____

If you have any of the following circle Yes or No

Are you under a physician's care now? Yes/No
Have you been hospitalized or had a serious illness?Yes/No
Date of last medical examination:
Physician's name:_____
Address:_____
Phone:_____
Are you pregnant? Yes/No Month:_____
Chest pains or angina pectoris? Yes/No
Heartattack? Yes/No
Months since heart attack?
Heart disease? Yes/No
Heart murmur? Yes/No Benign / Pathologic(regurgitating)
Shortness of breath when resting
or with little activity?Yes/No
Rheumatic fever or rheumatic heart disease? Yes/No
High blood pressure? Yes/No
Fainting spells, convulsions or epilepsy? Yes/No
Heart defect from birth? Yes/No
Stroke? Yes/No Month /Year_____
Diabetes? Yes/No
Insulin Tablets or Injections? (circle)
Anything important not asked? Yes/No
Kaiser record number:_____
Prescriptions are usually covered by Kaiser Health Plans

Lung disease (T.B., asthma,emphysema or other)? Yes/No
Nervous breakdown or emotional problems? Yes/No
Liver disease (hepatitis, jaundice, cirrhosis, etc.)? Yes/No
Kidney disease? Yes/No
Prolonged bleeding following injuries or surgery? Yes/No
Blood disorder (anemia or other)? Yes/No
Sexually transmitted diseases? Yes/No
HIV positive? Yes/No
Radiation therapy? Yes/No
Treatment for tumor or growth? Yes/No
Have you had joint surgery or a
prosthetic joint replacement? Yes/No
Have you become sick, shown allergy to, or been
told not to take the following:
Penicillin or other antibiotics? Yes/No
Latex?Yes/No
Bleach(Sodium hypochlorite)?Yes/No
Aspirin, codeine or other medications? Yes/No
Lidocaine (novocaine) or other anesthetics? Yes/No
Have you taken Fen Phen or Redux? Yes/No
List any other problem medications:

List any medications you are taking:

_____
Patient (Guardian) signature

Dental / Medical History