Patient Name _____ **Date** _____

Emergency Contact _____ **Phone** _____

Health Information

Physician Name _____ **Location/Town** _____**Phone**_____

Date of Last visit to Physician: _____

Pharmacy _____ **Street Location & Town** _____**Phone** _____

Do you currently have or ever had any of the following? Please check those that apply:

- ☐ AIDS/ HIV
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
  Last time & reason
  _____
- ☐ Auto Immune Diseases
- ☐ Blood Disease
- ☐ Blood Pressure
  High or Low
- ☐ Cancer Type
  _____
  Date: _____
- ☐ Cholesterol
- ☐ Depression/ Anxiety
- ☐ Diabetes Type I or II
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/ Seizures
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
  Type _____
- ☐ Herpes/ Cold Sores
- ☐ Jaundice
- ☐ Joint Replacement

Date: _____

- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Health Conditions
- ☐ Migraines
- ☐ Pacemaker
- ☐ Radiation Treatment
  Date _____
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sexually Transmitted Disease (STD)
- ☐ Sinus Problems
- ☐ Sleep Disorder
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen Ankles/ Feet
- ☐ Thyroid Disorder
  Hyper or Hypo
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers/ Reflux
- ☐ Vision Issues

<u>WOMEN ONLY</u>:

- ☐ Pregnant ___ # weeks
- ☐ Nursing
- ☐ Taking Birth Control

Are you currently being treated by a physician? YES NO

If yes, please explain_____

Have you had any serious illness, recent hospitalizations or surgeries in the last 5 years? YES NO

If yes, please explain_____

Do you have any health problems that need further clarification? YES NO

If yes, please explain _____

Do you use Tobacco? YES NO How much per Day? _____

Do you use controlled substances? YES NO Type _____ **How often?** _____

<u>ALLERGIES:</u>

(Seasonal/Drug)

- ☐ Penicillin
- ☐ Aspirin
- ☐ Latex
- ☐ Codeine
- ☐ Sulfa
- ☐ Erythromycin
- ☐ Dental Anesthetics
- ☐ OTHER: _____

_____

<u>MEDICATIONS</u> - Prescribed & Over the counter

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Dental History

Does Dental treatment make you nervous? YES NO Explain _____

What do you fear most about going to the dentist? _____

Have you ever had a bad reaction after a dental procedure? YES NO Explain _____

When was your last visit to the dentist & what was it for? _____

How often do you brush? (manual or power brush) _____ **How often do you floss?** _____

Have you or do you have any of the following:

- ☐ **Bad Taste**
- ☐ **Bite your cheek**
- ☐ **Bite your lip**
- ☐ **Bleeding Gums**
- ☐ **Broken Teeth**
- ☐ **Cold Sores**
- ☐ **Clicking Jaw**
- ☐ **Dentures or Partials**
- ☐ **Dry Mouth**
- ☐ **Gag Easily**
- ☐ **Gum Treatments**
- ☐ **Grind Teeth**
- ☐ **Jaw Pain**
- ☐ **Mouth Odors**
- ☐ **Orthodontic Treatment**
- ☐ **Sensitivity to Cold**
- ☐ **Sensitivity to Hot**
- ☐ **Sensitivity to Sweets**
- ☐ **Serious injury to the mouth**
- ☐ **Use a night Guard**
- ☐ **Use a Sports Guard**

List Others

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please answer the following questions by circling the option that best fits for you

1) **My mouth is…**
   a) **Very Comfortable**
   b) **Moderately Comfortable**
   c) **Uncomfortable**
2) **I…**
   a) **Think the appearance of my mouth is excellent**
   b) **Am satisfied with the appearance of my mouth**
   c) **Am dissatisfied with the appearance of my mouth**
3) **I…**
   a) **Will do anything needed to keep my natural teeth**
   b) **Want to keep my natural teeth, but I have a certain budget of time and money I am willing to spend on them**
   c) **Do not care whether or not I keep my natural teeth**
4) **I…**
   a) **Have set goals for my oral health**
   b) **Want to set goals for my oral health**
   c) **Never set goals for my oral health nor want to**
5) **I tend to…**
   a) **Put dentistry for myself and my family high on the priority list**
   b) **Put dentistry for myself and my family low on the priority list**
   c) **Put it on my list but rarely get to it**
6) **I have…**
   a) **Always done what was recommended for my dental health**
   b) **Not always done what was recommended for my dental health**
   c) **Rarely done what was recommended and do not care to have my dental work completed**
7) **My state of dental health is…**
   a) **Excellent**
   b) **Good**
   c) **Poor**
8) **I aspire to have a mouth that is in…**
   a) **Excellent health**
   b) **Good health**
   c) **Poor health**
9) **I would like to address…… at my appointment today** _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform South Shore Dentistry at the next appointment without fail.

Signature _____ **Date** _____