Smile Ft.Worth

HEALTH HISTORY AND DENTAL HEALTH EVALUATION

Welcome! Please complete both pages of this dental/medical history form so that we may create a treatment plan specialized for your individual needs. All information will be kept strictly confidential.

MEDICAL INFORMATION: PATIENT NAME: _____

1. Have you been under a physician's care in the past two years? . . . . . ☐ Yes ☐ No
2. If yes, for what? _____
3. Physician Name _____ Phone _____
4. Address _____ City _____ State _____ Zip _____
5. Are you currently taking any medications (including over-the-counter drugs or herbal remedies). . . . . ☐ Yes ☐ No
6. If yes, please list medication or substance: _____
7. Have you been hospitalized during the past five years? . . . . . ☐ Yes ☐ No
8. Please list any medication allergies: _____

CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD:

☐ Heart Disease, Heart Surgery, Heart Attack	☐ Tuberculosis	☐ Sleep Apnea	☐ Asthma
☐ Chest Pain	☐ Bruise Easily	☐ Latex Allergy or Sensitivity	☐ Liver Disease
☐ Heart Murmur	☐ Yellow Jaundice	☐ High Blood Pressure	☐ Allergies or Hives
☐ Sinus Trouble	☐ Neurological Disorders	☐ Mitral Valve Prolapse	☐ Radiation Therapy
☐ Epilepsy	☐ Artificial Heart Valve	☐ Chemotherapy	☐ Seizure Disorders
☐ Heart Pacemaker	☐ Tumors	☐ Fainting or Dizzy Spells	☐ Rheumatic Fever
☐ Hepatitis A (infectious)	☐ Nervous/Anxious	☐ Arthritis/Rheumatism	☐ Psychiatric/Psychological Care
☐ Hepatitis B (serum)	☐ Stroke	☐ Diabetes	☐ Artificial Joints (hip, knee, etc)
☐ Hepatitis C	☐ Herpes	☐ Emphysema	☐ Kidney Disease
☐ Ulcers	☐ A.I.D.S.	☐ H.I.V. Positive	☐ Headaches
☐ Substance Abuse	☐ Dry Mouth		

Have you ever taken:

Redux or Phen Fen? ☐ Yes ☐ No If yes, for how long _____

IMPORTANT: Have you been treated for thin bones (osteoporosis, Osteopenia)? If yes, please check:

☐ ACTONEL ☐ FOSAMAX ☐ BONIVA ☐ ZOMETA ☐ SKEUD
☐ OSTAC ☐ BONEFOX ☐ DIDRONEL

9. Do you have or have you had any disease, condition, or problem not listed above . . . . . ☐ Yes ☐ No
   If yes, please list: _____
10. Woman: Are you Pregnant? ☐ Yes _____ Months ☐ No Nursing? ☐ Yes ☐ No
    Planning Pregnancy? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

I understand that the above information is necessary in order to provide me with safe dental care. I have answered all questions to the best of my knowledge. Should further information be needed for my dental treatment or to fully understand any health condition I may have, I give my permission to contact my health care provider or agency who may release such information to this office. I will notify Drs. Batton, Harlin and/or Wilkinson of any changes in my health or medication.

Parent/Guardian Signature _____ Date _____

History Review Completed

Dentist Signature _____ Date _____ ASA Classification: _____

DENTAL HEALTH EVALUATION:

What is the reason for today's visit? _____

_____

How often do you have dental examinations? _____ Professional Cleanings? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

What other dental aids do you use to clean your teeth? (Interplak, toothpick, etc.) _____

Do you have any dental problems right now? ☐ Yes ☐ No If yes, how long has your dental problem bothered you? _____

Please describe _____

_____

Does having dental treatment make you afraid or nervous? ☐ Yes ☐ No if yes, what specific things bother you? _____

_____

Are your teeth sensitive to:
Hot temperatures? ☐ Yes ☐ No Does it linger? ☐ Yes ☐ No
Cold temperatures? ☐ Yes ☐ No Does it linger? ☐ Yes ☐ No
Sweets? ☐ Yes ☐ No
Biting or chewing pressure? ☐ Yes ☐ No
Have you noticed any mouth odors or bad tastes? ☐ Yes ☐ No
Do you frequently get cold sores, blisters,
Or any other oral lesion? ☐ Yes ☐ No

Have you ever had:
Orthodontic treatment (braces)? ☐ Yes ☐ No
Oral Surgery? ☐ Yes ☐ No
Periodontal treatment (gum treatment)? ☐ Yes ☐ No
Your teeth ground or the bite adjusted? ☐ Yes ☐ No
A bite plate or mouth guard? ☐ Yes ☐ No
A serious injury to your mouth or head? ☐ Yes ☐ No
please describe _____
Adverse reaction to dental anesthesia (numbing)? ☐ Yes ☐ No

Do your gums bleed or hurt (when brushing)? ☐ Yes ☐ No
Have your parents experienced gum disease or
tooth loss? ☐ Yes ☐ No
Have you noticed any loose teeth or change in
your bite: ☐ Yes ☐ No
Does food tend to become caught in between
your teeth? ☐ Yes ☐ No
Where? _____

Have you experienced:
Clicking or popping of the jaw? ☐ Yes ☐ No
Pain (joint ear, side of face)? ☐ Yes ☐ No
Difficulty opening or closing the mouth? ☐ Yes ☐ No
Difficulty in chewing on either side of the mouth? ☐ Yes ☐ No
Headaches, neck aches or shoulder aches? ☐ Yes ☐ No
Dry Mouth? ☐ Yes ☐ No

Are you allergic to: Metals? ☐ Yes ☐ No
Some Jewelry? ☐ Yes ☐ No
Acrylic? ☐ Yes ☐ No
Artificial Fingernails? ☐ Yes ☐ No
Allergic to any medications? _____

Do You:
Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No
Have a family member that clenches or grinds? ☐ Yes ☐ No
Have tired jaws or headaches, especially in the
morning? ☐ Yes ☐ No
Smoke/chew tobacco? ☐ Yes ☐ No ☐ How long? _____

Are you happy with the appearance of your teeth? ☐ Yes ☐ No
Would you like to keep your teeth all of your life? ☐ Yes ☐ No

If you could change anything about your smile, which of the following would you want?

☐ Whiter
☐ Straighter
☐ Close Space or Spaces
☐ Replace Missing Teeth
☐ Less Gum Showing
☐ Replace Old Crowns
☐ Excess Showing of Teeth
☐ Replace Old Plastic Fillings
☐ Reshape/Resize my Teeth
☐ Replace Chipped Teeth
☐ Remove Silver Fillings
☐ Remove Stains/Spots on Teeth