CANTON PARK DENTAL

DATE _____

NAME _____ BIRTH DATE _____

ADULT MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM _____

ARE YOU CURRENTLY TAKING ANY DRUGS OR MEDICATION? _____

FOR WHAT PURPOSE? _____

YES NO ....Are you now under the care of a physician? If so, what is the condition being treated? _____

YES NO ....Have you had any serious illness or operation? If yes, what was the illness or operation? _____

YES NO ....Have you been hospitalized in the past five (5) years? _____

Have you ever been treated for:

Heart disease ..... Yes ☐ No ☐
Rheumatic fever ..... Yes ☐ No ☐
Abnormal blood pressure ..... Yes ☐ No ☐
Ulcers ..... Yes ☐ No ☐
Tuberculosis or lung disease ..... Yes ☐ No ☐
Diabetes ..... Yes ☐ No ☐
Epilepsy ..... Yes ☐ No ☐
Anemia ..... Yes ☐ No ☐
Congenital heart lesions ..... Yes ☐ No ☐
Cardiac Pacemaker ..... Yes ☐ No ☐
Heart murmur ..... Yes ☐ No ☐
Jaundice ..... Yes ☐ No ☐
Asthma or hay fever ..... Yes ☐ No ☐

Sinus trouble ..... Yes ☐ No ☐
Cough ..... Yes ☐ No ☐
Hepatitis ..... Yes ☐ No ☐
Arthritis ..... Yes ☐ No ☐
Stroke ..... Yes ☐ No ☐
Glaucoma ..... Yes ☐ No ☐
Venereal disease ..... Yes ☐ No ☐
AIDS ..... Yes ☐ No ☐
Are you in a high-risk group for AIDS or Hepatitis? ..... Yes ☐ No ☐
Have you ever required a blood transfusion? ..... Yes ☐ No ☐
If yes, explain the circumstances: _____

Have you ever been treated (other than diagnostic) with x-ray? ..... Yes ☐ No ☐

Allergies: Aspirin ☐ Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ☐

Are you subject to prolonged bleeding? ..... Yes ☐ No ☐
Do you have excessive urination and/or thirst? ..... Yes ☐ No ☐
Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes ☐ No ☐
If yes, explain: _____
Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ..... Yes ☐ No ☐
Women: Are you pregnant? ..... Yes ☐ No ☐

(please see other side for dental history)

DENTAL HISTORY

What is the reason for this visit? _____

When was your last dental visit? _____

What was done at that visit? _____

When was your last set of x-rays taken? _____

Have you ever had a bad experience in a dental office? _____

Have you had any serious trouble associated with any previous dental treatment? ..... Yes ☐ No ☐

If yes, explain: _____

Have you ever been treated by a dental specialist? Periodontist ☐ Orthodontist ☐ Oral Surgeon ☐ Other ☐

Give details: _____

Do you have pain or clicking or grating in your jaw joints? ..... Yes ☐ No ☐

Do you have trouble opening wide? ..... Yes ☐ No ☐

Do you favor one side when you chew? ..... Yes ☐ No ☐

Do you get frequent headaches or earaches? ..... Yes ☐ No ☐

Do you grind your teeth at night? ..... Yes ☐ No ☐

Do you clench or grind when tense? ..... Yes ☐ No ☐

Have you ever been treated for a bite problem? ..... Yes ☐ No ☐

Are any of your teeth sensitive to: Sweet ☐ Cold ☐ Hot ☐ Chewing ☐ Brushing or Flossing ☐

Do you get food caught between your teeth? ..... Yes ☐ No ☐

Do your gums bleed? Yes ☐ No☐ When? _____

Do you get a bad taste from your gums or teeth? ..... Yes ☐ No ☐

Do you have any loose teeth? ..... Yes ☐ No ☐

Have you ever had gum treatment? ..... Yes ☐ No ☐

How do you feel about the appearance of your teeth? _____

What would you change about them? _____

(Signature) (Date)