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)