I Smile Dentistry
Patient Dental and Medical History
(949)333-2717

Why have you come in to see us today? (e.g.: pain, checkup, etc.)_____

Previous Dentist _____ Date of last visit _____Date of last cleaning_____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? Yes! No If yes, please tell us why: _____

How often do you brush? Do you floss? Yes No If yes, how often?

(Please circle each answer)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straight.
Y N I want my teeth whiter.

What are your dental priorities _____ (e.g.: apprentice, dental health, financial considerations, etc.)

I consider my health to be Excellent Good Fair Poor

Do you or have had any or the following? **(Please circle each answer)**

1. Y N Heart Disease
2. Y N Heart murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N History of Emotional or Nervous disorder
14. Y N Ulcers
15. Y N Implants/Artificial Joints: Hip Knee Other
16. Y N I smoke/use tobacco. If yes, how much per day?_____ How long? _____
17. Y N I have consumed alcohol within the last 24 hours
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken/do you take bisphosphonates, i.e.: Fosamax?
22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type____
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis (Mono)
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Disease
31. Y N Kidney Disease
32 Y N Tumor or Malignancy
33 Y N Cancer/Chemotherapy
34. Y N Radiation treatment
35. Y N History of Drug Addiction
36. Y N Aids
37. Y N Immune Suppressed Disorder
38. Y N Hearing Loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N Epilepsy/Seizures

Doctor Notes Only:

WOMEN:
42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

20. Y N I have had major surgery: Year_____ of operation:_____ Year_____ Type of operation:_____
21. Y N Do you have any other medical problem or medical history NOT listed on this form_____

Are you allergic to any of the following?

44. Y N Aspirin
45. Y N ibuprofen
46. Y N Sulfa Drugs/Sulfites/Sulfides
47. Y N Penicillin
48. Y N Codeine
49. Y N Latex, Metals, Plastics
50. Y N Local anesthetics (Novocain)
51. Y N Other Medications- Which ones?

Please list all medication you are currently taking:

Medicine _____ Condition_____
Medicine _____Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____

Physician's Name_____ Phone no_____
Address_____ Fax no_____

X_____/____/_____
Initial health review: Doctor's Signature Date

X_____/____/_____
Patient signature Date

X_____/____/_____
Periodic review: Doctor's Signature Date

X_____/____/_____
Patient Signature Date