**Patient Name:______________________________**

# DENTISTRY OF BETHESDA

## DENTAL HEALTH HISTORY

**Reason for today's visit: □ Exam □ Emergency □ Consultation** Are you in pain: □ Yes □ No For how long:_________

Do you require pre-medication: □ Yes □ No □ Don't know Previous Dentist:______________________________________________
Name Tel #

Date of Last Dental Exam:___________________________ Date of last X-rays:____________________ Do you have copies □ Yes □ No

Times a Day you Brush:_________ Times a week you Floss:______ How would you rate your smile? 1 2 3 4 5 6 7 8 9 10 (best)

Have you ever had complications after dental care: □ Yes □ No If yes please explain _______________________________________

In the dental office have you ever had Nitrous Sedation? □ Yes □ NO, Oral sedation? □Yes □ No, General Anesthesia? □ Yes □ No

Is there a specific area of dental treatment you believe you need? □ Yes □ No Do you take Fossamax? □ Yes □ No

Would you like to options to improve your smile? □ Yes □ No _________________________________________________________

Have you ever had your teeth whitened? □ Yes □ No If yes what method(s)? ____________________________________________

Do you have any Dental Implants? □ Yes □ No Do you have any dental fears? □ Yes □ No

**Please indicate any of the following problems by checking off the corresponding box**

☐Discomfort, clicking or popping in the jaw ☐Lost /Broken Filling(s) ☐Stained Teeth ☐Difficulty closing jaw
☐Red swollen or bleeding gums ☐Teeth grinding/clenching ☐Locking jaw ☐Swelling/lumps in mouth
☐Sensitive tooth, teeth or gums ☐Ringing in ears ☐Bad Breath ☐Loose/shifting teeth
☐Blisters/sores around the mouth ☐Broken/chipped teeth ☐Burning tongue ☐Food caught between teeth

☐My teeth are sensitive to: ☐Hot ☐ Cold ☐ Sweets ☐ Biting ☐Other:________________________________________

□ TMJ/TMD If so do you wear a mouthguard?___________________________________ Have you ever had your teeth equilibrated/adjusted? □ Yes □ No

## MEDICAL HEALTH HISTORY

Are you in good health: □ yes □ no Primary Care Physician:______________________________________ Dr. Tel. #_____________________________

Have you had any illness, operation, or been hospitalized in the past 5 years: □ Yes □ No If Yes explain:____________________________________________

**Are you taking any of the following medications**: ☐Muscle relaxers ☐ Nerve Pills ☐Pain Killers (including aspirin) ☐Stimulants ☐ Blood Thinners

☐Tranquilizers ☐ Insulin/Diabetes Meds. □ Herbal supplements If so, list purpose_____________________________________________

☐Other (please list and state purpose)_____________________________________________________________________________

**Do you have or have you had any of the following diseases, medical conditions or procedures?**

**Y N**
☐ ☐ Heart Attack/Stroke
☐ ☐ Heart Surg./Pacemaker
☐ ☐ Angina
☐ ☐ Internal Defibrillator
☐ ☐ Heart Stint
☐ ☐ Heart Murmur
☐ ☐ HIV/AIDS/ARC
☐ ☐ Mitral Valve Prolapse
☐ ☐ Artificial Valves
☐ ☐ Heart Disease
☐ ☐ Congenital Heart Defect
☐ ☐ Chest Pains
☐ ☐ Artificial Bones/Joints
☐ ☐ Nervousness
☐ ☐ Eating Disorder/Anorexia/Bulimia

**Y N**
☐ ☐ Thyroid Problems
☐ ☐ Kidney Problems
☐ ☐ Rheumatic Fever
☐ ☐ Respiratory Problems
☐ ☐ Scarlet Fever
☐ ☐ Liver Problems
☐ ☐ Asthma
☐ ☐ Sinus Problems
☐ ☐ Stomach Problems
☐ ☐ Psychiatric Challenges
☐ ☐ Venereal Disease
☐ ☐ Alcohol/Drug Abuse
☐ ☐ Back Problems
☐ ☐ Glaucoma

**Y N**
☐ ☐ Cancer/Tumors
☐ ☐ Shingles
☐ ☐ Chemotherapy
☐ ☐ Tuberculosis
☐ ☐ Difficulty Breathing
☐ ☐ Hepatitis
☐ ☐ Diabetes/Hypoglycemia
☐ ☐ Arthritis/Rheumatism
☐ ☐ Emphysema
☐ ☐ Fainting/Seizures/Epilepsy
☐ ☐ Severe/Frequent Headaches
☐ ☐ Frequent Neck Pain
☐ ☐ Bleeding Problems

**Y N**
☐ ☐ Cosmetic Surgery
☐ ☐ X-Ray/Cobalt Treatment
☐ ☐ High/Low Blood Pressure
☐ ☐ Anemia
☐ ☐ Leukemia

**Please list any other medical conditions you have or ever had:** ______________________________________________________________

**Are you allergic to the following: ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Sulfites ☐ Sulfa Drugs ☐ Dental Anesthetics ☐ Others:**_____________________________________________________

Do you use tobacco? ☐ Yes ☐ No / If yes how much and how long? ________________________

Please rate your general health from 1-10 (10 = excellent) Do you wear contact lenses? ☐ Yes ☐ No

Have you ever taken the Phen-fen or Redux? ☐ Yes ☐ No

**For Women:** Are you taking Birth Control Pills? ☐ Yes ☐ No   Are you Pregnant: ☐Yes ☐ No If so, Due Date:_____________

How many children have you had? _________ Are you nursing?_______

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

**I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims and consult with referring doctors in compliance with HIPPA standards.**

____________________________________________   _____/____/_______
Signature ☐Patient ☐Guardian   Date

**Office Use Only**

**Notes:**_____________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________