Welcome to East Oak Dental

GENERAL HEALTH INFORMATION

Name_____Date_____

1. Who is your Primary **Medical Doctor**?_____
2. Are you under a doctor's care for any serious illness?_____
3. Are you allergic to **Latex**? Yes No
4. Are you allergic to **Penicillin** or any other antibiotics? Yes No If **Yes** please specify:_____
5. Please list all **allergies**:_____
6. Please list **medications** you are taking:_____

_____

_____

7. (Women) Are you **Pregnant?** Yes No

8. Do you have, or have had, any of the following? **(circle Yes or No)**

Artificial Heart Valve	Yes	No	**Fainting**	Yes	No	**Pacemaker**	Yes	No
AIDS/HIV	Yes	No	**Heart attack**	Yes	No	**Rheumatic fever**	Yes	No
Anemia	Yes	No	**Heart surgery**	Yes	No	**Seizures**	Yes	No
Angina/Chest Pain	Yes	No	**Heart murmur**	Yes	No	**Sinus trouble**	Yes	No
Asthma	Yes	No	**Hepatitis**	Yes	No	**Sleep apnea**	Yes	No
Bleeding problems	Yes	No	**High blood pressure**	Yes	No	**Tobacco use**	Yes	No
Cancer	Yes	No	**Joint replacement**	Yes	No	**Thyroid problems**	Yes	No
Chemo/Rad Therapy	Yes	No	**Kidney disease**	Yes	No	**Tuberculosis**	Yes	No
Diabetes	Yes	No	**Liver disease**	Yes	No	**Stroke**	Yes	No
Epilepsy	Yes	No	**Low blood pressure**	Yes	No			

9. Please elaborate on any of the above **Yes** answers or anything else in your medical history that you think the dentist should know about:_____

_____

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DENTAL HISTORY

Name_____Date_____

1. Reason for today's **Dental Visit:**_____
2. How long since your **last dental visit**?_____
3. How long since your **last dental cleaning**?_____
4. Previous **Dentist/Clinic** Name_____
5. What **treatment** was performed there?_____
6. Why did you leave your **previous dentist**?_____
7. Have you had any problems with **past dental treatment**?_____
8. Please circle **Yes or No**:

Yes	No	Have you had any **bad reactions** to any dental treatment or dental products used at the dentist?
Yes	No	Have you ever had **prolonged bleeding** after an extraction?
Yes	No	Do you **grind or clench** your teeth?
Yes	No	Do you have symptoms near your ear such as **clicking, popping, pain, or locking open**?
Yes	No	Have you ever been diagnosed or treated for **TMD**, sometimes called **TMJ**?
Yes	No	Do you have any problems with **snoring or sleep apnea**?
Yes	No	Do your gums **bleed easily**?
Yes	No	Do you have **bad breath**?
Yes	No	Do any of your **teeth hurt** when you bite on them?
Yes	No	Does **hot or cold** cause your teeth to hurt?

9. Please explain any of the above **Yes** answers_____
_____

10. Is there anything else in your **dental history** you would like the dentist to know about?_____
_____

To the best of my knowledge, I have answered every Health and Dental History question completely and accurately. I will inform the dentist of any changes in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's Signature (or Responsible Party)_____Date_____