Shelby Family Cosmetic & Restorative Dentistry

Patient health information

NAME: **DATE:**

Oral Health Information:

1. Any known dental problems at this time? Yes___ No ___ Describe_____
2. Are any of your teeth sensitive to hot or cold , biting pressure or sweets? Yes___No___ Describe_____
3. Do your gums bleed when you brush or floss? Yes___No___ Describe_____
4. Have you ever been told you have periodontal (gum) Disease? Yes___ No___
5. Are there any areas of your mouth that you avoid chewing on? Yes___No___ Describe _____
6. Have you had any dental checkup xrays in the past year? Yes___No___ Describe_____
7. Do your jaw joints (TMJ) click, Pop, or cause pain? Yes___ No ___ Describe_____
8. Are you aware of any nighttime clenching or grinding of your teeth? Yes___ No___
9. Have you had your wisdom teeth removed? Yes___ No ___
10. Are you missing any other teeth? Yes___ No ___ For how long?_____
11. Do Your teeth show signs of chipping and wear? Yes___No___ Describe _____
12. Do you have a replacement for missing teeth? Yes___No____ Describe _____

Medical Health Information

1. Physician's Name_____Date last seen:_____
2. Are you under a physician's care now? Yes____No____ explain reason? _____
3. Hospitalizations in the past 5 years? Yes___ No___
4. Have you had any serious illnesses or operations? Yes __ No__
5. Are you currently any medications over the counter or prescription? Yes __ No___ Please List:_____
6. Are you allergic to any medication or substances? Please list: _____ _____
7. Women (please check if applicable) Pregnant (Due date _____) are you nursing?
8. Do you have, or have you ever had, any of the following? (Please check all that apply)

__ Rheumatic fever __excessive bleeding __Fainting or dizziness __heart issues __Hepatitis

__Stroke __Need dental Pre-medication __AIDS exposure __Diabetes __High blood pressure

__TB __psychiatric treatment __Cancer __Epilepsy or seizures __Other discuss: _____

_____

Do you know of any reason why routine dental procedures might pose a risk to you, the dental staff, or other patients?

__yes __no

Is there anything important about your medical condition that was have not asked?

_____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PROCEDING ANSWERS ARE CORRECT. IF I HAVE ANY CHANGES TO MY HEALTH STATUS OR IF MY MEDICATIONS CHANGE, I SHALL INFORM THE DENTIS AND STAFF AT THE NEXT DENTAL APPOINTMENT WITH OUT FAIL.

* _____ DATE:_____

PATIENTS SIGNATURE (PARENT OR GUARDIAN)