DENTAL HISTORY *UPDATE*

BROWN FAMILY DENTISTRY

Patient's Name _____

Please check the following:	**YES**	**NO**
-Sensitivity (hot, cold, sweet)	☐	☐
-Tooth pain or discomfort when chewing	☐	☐
-Headaches, earaches, neck pain	☐	☐
-Jaw joint pain	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
-Bad breath or bad taste in your mouth	☐	☐

	YES	**NO**
If you could whiten your teeth for a cost anyone could afford, whould you do it?	☐	☐
Do you smoke or use chewing tobacco?	☐	☐
How much? For how long?		
If I could change my smile, I would:		
-Make them brighter	☐	☐
-Make them straighter	☐	☐
-Close spaces	☐	☐
-Replace black metal fillings with natural, tooth-colored fillings	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Repair chipped teeth	☐	☐
-Replace old crowns that don't match	☐	☐

On a scale of 1–10, with 10 being the highest rating:

-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

- How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?

_____

What is the most important thing to you about your future smile and dental health?

_____

MEDICAL HISTORY *UPDATE*

Please check any of the following that apply to you:

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Drug Addiction	☐	☐	HIV	☐	☐	Rheumatic Fever
☐	☐	Allergies (Seasonal)	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Rheumatism
☐	☐	Anemia	☐	☐	Excessive Bleeding	☐	☐	Jaw Joint Pain	☐	☐	Scarlet Fever
☐	☐	Arthritis	☐	☐	Fainting	☐	☐	Kidney Disease	☐	☐	Seizures
☐	☐	Artificial Heart Valve	☐	☐	Glaucoma	☐	☐	Liver Disease	☐	☐	Stomach Problems
☐	☐	Artificial Joints	☐	☐	Heart Conditions	☐	☐	Low Blood Pressure	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Heart Lesions (Congenital)	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Disease
☐	☐	Blood Disease	☐	☐	Heart Murmur	☐	☐	Nervousness/Depression	☐	☐	Tuberculosis
☐	☐	Chemotherapy	☐	☐	Heart Surgery	☐	☐	Pacemaker	☐	☐	Ulcers
☐	☐	Cancer	☐	☐	Hepatitis A	☐	☐	Phen Fen (1 month +)	☐	☐	Venereal Diseases
☐	☐	Chemotherapy	☐	☐	Hepatitis B	☐	☐	Pregnant Currently	☐	☐	Other
☐	☐	Diabetes	☐	☐	Hepatitis C	☐	☐	Radiation (head/neck)			_____
☐	☐	Dizziness	☐	☐	High Blood Pressure	☐	☐	Respiratory Problems			_____

Do you have an allergy to any of the following?

☐	☐	Aspirin	☐ ☐ Nitrous Oxide
☐	☐	Erythromycin	☐ ☐ Codeine
☐	☐	Latex	☐ ☐ Penicillin
☐	☐	Local Anesthetic	☐ ☐ Other:

Are you under a physician's care? What for?

_____

Are you taking any medications? What?

_____

_____

Is there any other Medical or Dental Information We Should Know About? _____

_____

_____

Patient Signature (Parent of Child) Date Dentist Signature Date