Galvin & Round Family Dentistry

Patients Dental Health

Name:____

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

Previous dentist:____________________________ Last visit:___________________ Date of last cleaning:______________________________

Reason for changing dentists:____

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 ______ How Often:__________________________________

(please circle each)

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 facial or jaw injury

Y N I want my teeth straight

Y N I want my teeth white

What are your dental priorities?

Patients Medical History

I consider my health to be (please check one) Excellent:____ Good:____ Fair:____ Poor:____

Do you or have you had any of the following? Please circle Y for yes or N for no.

1. Y N Heart Disease.
2. Y N Heart Murmur/Mitral Prolepses.
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 Disorder.
10. Y N Asthma.
11. Y N Hay Fever.
12. Y N Sinus Trouble.
13. Y N Epilepsy/Seizures.
14. Y N Ulcers.
15. Y N Implants/Artificial Joints. Hip:___ Knee:___ Other:____
16. Y N I smoke or use Tobacco. If Yes. Per day:_____ How many Years:______
17. Y N I have consumed alcohol in the past 24 Hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery: Year:______ Type or operation:___________________________________
21. Y N Do you have any other medical problem or medical history **NOT** listed on this form?____
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 STD's.
31. Y N Kidney Diseases.
32. Y N Tumor or Malignancy.
33. Y N Cancer/Chemotherapy.
34. Y N Radiation Treatment.
35. Y N History of drug Addiction.

Doctor Notes Only:

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 History of emotional or Nervous Disorders.

Women:

42. Y N Are you taking birth control Medication?
43. Y N Are you or could you be pregnant Or nursing?

Are you allergic to any of the following?
Please Circle Y for yes and N for No.

44. Y N Aspirin.
45. Y N Ibuprofen.
46. Y N Sulfa Drugs/Sulfates/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 medications you are currently taking:

Medicine: Condition:

Medicine: Condition:

Medicine: Condition:

Medicine: Condition:

Medicine: Condition:

Physician's Name:________________________ Phone:________________

Address:________________________________ Fax:_________________

In the event of an emergency please contact:

Name:____ Relationship:________________________ Phone:___________________________

Name:____ Relationship:________________________ Phone:___________________________

Initial medical/dental health reviewed by:

X ____ ____/____/____ X ____ ____/____/____

Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X ____ ____/____/____ X ____ ____/____/____

Doctor's Signature Date If Patient is a minor: Parent/Guardian's Signature Date