HOWARD Family Dental®

Patient's Name (Please print): _____

Dental History

Please check any of the following that apply to you:

- ❑ Sensitivity (hot, cold, sweets, pressure)
- ❑ Discomfort when chewing
- ❑ Headaches, ear aches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or fillings breaking
- ❑ Bad breath or bad taste in your mouth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, chipped tooth/teeth
- ❑ Grinding or clenching teeth

Do you have or have you ever had any of the following?

- ❑ Dentures ❑ Braces
- ❑ Partial Dentures ❑ Periodontal (gum) treatments

What would you like to do to improve your smile?

- ❑ Whiten
- ❑ Straighten
- ❑ Close spaces
- ❑ Replace silver fillings with tooth colored filings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns that don't match other teeth

How long has it been since your last cleaning?

❑ < 1 yr ❑ 1-2 yrs ❑ 3-5 yrs ❑ > 5 yrs

What is the most important thing about your visit today? _____

_____ _____ _____

Name of previous dentist | City & State | Phone number

Reason for leaving your previous dentist? _____

_____

Previous dental experiences: _____

Please circle: On a scale from 1 to 10 with 10 being the highest:

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

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

Sleep History

Have you ever had a sleep study or do you currently use a CPAP? ❑ Yes ❑ No

Does your partner say that you snore? ❑ Yes ❑ No

Do you take frequent naps during the day, or often feel tired? ❑ Yes ❑ No

Other: _____

Medical History

Have you been under the care of a medical doctor during the past two years? ❑ Yes ❑ No

If yes, for what? _____

Physician's name: _____ Last visit to Physician: _____

Do you have high blood pressure? ❑ Yes ❑ No What is your normal blood pressure? _____

Emergency Contact: _____ Phone Number: _____

Are you allergic or have you had a reaction to the following:

Local Anesthetic	❑ Yes	❑ No
Penicillin or other antibiotics	❑ Yes	❑ No
Aspirin, Ibuprofen or Tylenol	❑ Yes	❑ No
Codeine, Valium or other sedatives	❑ Yes	❑ No
Latex or metals	❑ Yes	❑ No

Updates:

Initials _____ Date _____

Initials _____ Date _____

Initials _____ Date _____

Initials _____ Date _____

Patient's Signature: _____

Doctor's Signature: _____

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? ❑ Yes ❑ No

If yes, please list: _____

_____

Are you currently taking any medications, drugs or pills? ❑ Yes ❑ No

If yes, please list name and dosage: _____

_____

Do you use tobacco? ❑ Yes ❑ No If yes, ❑ Chew ❑ Smoke How often? _____ For How Long? _____

Do you consume alcohol? ❑ Yes ❑ No If yes, how many beverages per week? _____

Do you use any mood altering drugs other than those previously listed? ❑ Yes ❑ No

Have you had or now have the following conditions or treatments?

AIDS	❑ Yes ❑ No	Heart condition	❑ Yes ❑ No
Alcoholism	❑ Yes ❑ No	Heart murmur	❑ Yes ❑ No
Allergies or hives	❑ Yes ❑ No	Heart pacemaker	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Heart surgery	❑ Yes ❑ No
Arthritis/Rheumatism	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No
Artificial heart valve	❑ Yes ❑ No	Hepatitis type _____	❑ Yes ❑ No
Artificial joints-type _____	❑ Yes ❑ No	High blood pressure	❑ Yes ❑ No
Bleeding/Blood disorder	❑ Yes ❑ No	HIV positive	❑ Yes ❑ No
Blood thinners/Aspirin	❑ Yes ❑ No	HPV	❑ Yes ❑ No
Bone disease or bone cancer	❑ Yes ❑ No	Kidney trouble	❑ Yes ❑ No
Bruise easily	❑ Yes ❑ No	Latex sensitivity	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Liver disease	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Milk/Casein allergy	❑ Yes ❑ No
Chest pain (Angina)	❑ Yes ❑ No	Mitral valve prolapse	❑ Yes ❑ No
Chronic cough	❑ Yes ❑ No	Neurological disorders	❑ Yes ❑ No
Cold sores/Fever blisters	❑ Yes ❑ No	Nervous/Anxious	❑ Yes ❑ No
Congenital heart disease	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
Contact lenses	❑ Yes ❑ No	Psychiatric/Psychological care	❑ Yes ❑ No
Cortisone medicine	❑ Yes ❑ No	Radiation therapy	❑ Yes ❑ No
Diabetes: Type _____	❑ Yes ❑ No	Rheumatic fever	❑ Yes ❑ No
Drug addiction	❑ Yes ❑ No	Sinus trouble	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Sleep apnea/Snoring	❑ Yes ❑ No
Epilepsy or seizures	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Fainting or dizzy spells	❑ Yes ❑ No	Thyroid problems	❑ Yes ❑ No
Family history of diabetes	❑ Yes ❑ No	Tuberculosis (T.B.)	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No	Tumors	❑ Yes ❑ No
Heart attack	❑ Yes ❑ No	Ulcers/Reflux	❑ Yes ❑ No

Premedication Required: ❑ Yes ❑ No

Any disease, condition or problem that is not listed: _____

Women

Are you pregnant or planning a prenancy? ❑ Yes ❑ No If yes, due date: _____

Are you a nursing mother? ❑ Yes ❑ No

Do you take birth control pills? ❑ Yes ❑ No

Patient Name (Please Print) _____

Patient/Parent signature _____ **Date** _____

Doctor Signature _____ **Date** _____