870 11th Avenue, Longview, WA, 98632
360.425.4900 fax 360.636.4641
advanceddentalservices@hotmail.com
www.advanceddentalservices.com

Please answer all questions and fill in blank spaces where indicated.

This information is for our records only and will be strictly confidential.

Health Information:

Patient Name: ______________________________ Date of Last Visit: _____/_____/_____

Do you have a personal physician? ❑ yes ❑ no Physician's Name: ______________________________

Are you currently under the care of a physician? ❑ yes ❑ no Please Explain: ______________________________

Anything you would like to discuss with the dentist in private? ❑ yes ❑ no

Please list any serious medical condition(s) that you have ever had: ______________________________

Dental History:

01. Previous Dentist: ______________________________ Date of Last Visit to the Dentist: ______________

02. Why have you come to the dentist today? ______________________________

03. Your current dental health is: ❑Good ❑Fair ❑Poor

04. *Please check yes or no for each of the following:*

Are you apprehensive about dental treatment? -------------------- ❑ yes ❑ no

Have you ever had problems with previous dental treatment? ------ ❑ yes ❑ no

Do you gag easily? -- ❑ yes ❑ no

Do you wear dentures? -- ❑ yes ❑ no

Does food catch in your teeth? ------------------------------------ ❑ yes ❑ no

Do you have difficulty in chewing your food? ---------------------- ❑ yes ❑ no

Do you chew on only one side of your mouth? --------------------- ❑ yes ❑ no

Do you avoid brushing any part of your mouth due to pain? -------- ❑ yes ❑ no

Do your gums bleed easily? -- ❑ yes ❑ no

Do your gums bleed when you floss? ------------------------------- ❑ yes ❑ no

Do your gums feel swollen or tender? ------------------------------ ❑ yes ❑ no

Have you ever had slow-healing mouth sores inside or out? ------- ❑ yes ❑ no

Are your teeth sensitive? -- ❑ yes ❑ no

Do you feel twinges of pain when your teeth come in contact with:

Hot foods or liquids? -- ❑ yes ❑ no

Cold foods or liquids? --- ❑ yes ❑ no

Sours? --- ❑ yes ❑ no

Sweets? -- ❑ yes ❑ no

Do you take fluoride supplements? -------------------------------- ❑ yes ❑ no

Are you dissatisfied with the appearance of your teeth? ----------- ❑ yes ❑ no

Do you prefer to save your teeth? --------------------------------- ❑ yes ❑ no

Do you want complete dental care? -------------------------------- ❑ yes ❑ no

Do you brush often? --- ❑ yes ❑ no

Do you floss often? -- ❑ yes ❑ no

Does your jaw make noises that bother you or others? ------------- ❑ yes ❑ no

Do you clench or grind your jaws frequently? ---------------------- ❑ yes ❑ no

Do your jaws ever feel tired? --------------------------------------- ❑ yes ❑ no

Does your jaw get stuck so that you can't open freely? ------------- ❑ yes ❑ no

Does it hurt when you chew or open wide to take a bite? ------------ ❑ yes ❑ no

Do you have earaches or pain in front of the ears? ------------------ ❑ yes ❑ no

Do you have any jaw symptoms or headaches when you awake? ----- ❑ yes ❑ no

Does your jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? ---------------------------------- ❑ yes ❑ no

Do you find jaw pain or discomfort extremely frustrating? ------------ ❑ yes ❑ no

Do you take medications for jaw pain or discomfort (pain relievers, muscle relaxants, antidepressnats)? --------------- ❑ yes ❑ no

Do you have temporomandibular (jaw) disorder (TMD)? -------------- ❑ yes ❑ no

Do you have pain in the face, cheeks, jaws, joints, throat or temples? --- ❑ yes ❑ no

Are you unable to open your mouth as far as you want? -------------- ❑ yes ❑ no

Are you aware of an uncomfortable bite? ----------------------------- ❑ yes ❑ no

Have you had a blow to the jaw (trauma)? ---------------------------- ❑ yes ❑ no

Are you a habitual gum chewer or pipe smoker? ---------------------- ❑ yes ❑ no

Do you like your smile? --- ❑ yes ❑ no

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Medical History: *Do you have, or have you had, any of the following:*

05. HEART PROBLEMS
- Chest Pain ❑ yes ❑ no
- Shortness of Breath ❑ yes ❑ no
- Blood Pressure Problem ❑ yes ❑ no
- Heart Murmur ❑ yes ❑ no
- Heart Valve Problem ❑ yes ❑ no
- Taking Heart Medication ❑ yes ❑ no
- Rheumatic Fever ❑ yes ❑ no
- Pacemaker ❑ yes ❑ no
- Artificial Heart Valve ❑ yes ❑ no

06. BLOOD PROBLEMS
- Easy Bruising ❑ yes ❑ no
- Frequent Nosebleeds ❑ yes ❑ no
- Abnormal Bleeding ❑ yes ❑ no
- Blood Disease (Anemia) ❑ yes ❑ no
- Blood Transfusion ❑ yes ❑ no

07. ALLERGY PROBLEMS
- Hay Fever ❑ yes ❑ no
- Sinus Problems ❑ yes ❑ no
- Skin Rashes ❑ yes ❑ no
- Taking Allergy Medication ❑ yes ❑ no
- Asthma ❑ yes ❑ no

08. INTESTINAL PROBLEMS
- Ulcers ❑ yes ❑ no
- Weight Gain or Loss ❑ yes ❑ no
- Special Diet ❑ yes ❑ no
- Constipation/Diarrhea ❑ yes ❑ no
- Kidney or Bladder Problems ❑ yes ❑ no

09. BONE OR JOINT PROBLEMS
- Arthritis ❑ yes ❑ no
- Back or Neck Pain ❑ yes ❑ no
- Joint Replacement ❑ yes ❑ no
  (e.g. total hip, pins or implants)

10. IN THE PAST 12 MONTHS, HAVE YOU TAKEN:
- Antibiotics or Sulfa Drugs ❑ yes ❑ no
- Anticoagulants ("Coumadin") ❑ yes ❑ no
- High Blood Pressure Meds ❑ yes ❑ no
- Tranquilizers ❑ yes ❑ no
- Insulin, Orinase, etc. ❑ yes ❑ no
- Aspirin ❑ yes ❑ no
- Digitalis (or other heart drugs) ❑ yes ❑ no
- Cortisone (Steroids) ❑ yes ❑ no
- Natural Remedies ❑ yes ❑ no
- Nonprescription Drugs ❑ yes ❑ no
- Supplements ❑ yes ❑ no
- Other: ______________________________

11. DIABETES
- Do you have diabetes? ❑ yes ❑ no
- Do you urinate more than 6 times a day? ❑ yes ❑ no
- Thirsty or mouth is dry much of the time? ❑ yes ❑ no
- Family History of Diabetes ❑ yes ❑ no

12. OTHER
- Tuberculosis or Respiratory Disease ❑ yes ❑ no
- Strokes or TIA (Transient Ischaemic Attack) ❑ yes ❑ no
- Frequent or Severe Headaches ❑ yes ❑ no
- Thyroid Disease or Thyroid Problems ❑ yes ❑ no
- Persistent Cough or Swollen Glands ❑ yes ❑ no
- Premedications Required by Physician ❑ yes ❑ no
- Cancer or Tumor ❑ yes ❑ no
- Do you drink alcohol? ❑ yes ❑ no If so, how much? __________________
- Do you chew/smoke tobacco? ❑ yes ❑ no If so, how much? ____________
- History of Alcohol or Drug Abuse ❑ yes ❑ no
- Hepatitis, Jaundice or Liver Trouble ❑ yes ❑ no
- Herpes or Other STD ❑ yes ❑ no
- HIV-positive or AIDS ❑ yes ❑ no
- Glaucoma or Eye Disease ❑ yes ❑ no
- Do you wear contact lenses? ❑ yes ❑ no
- History of Head Injury ❑ yes ❑ no
- Epilepsy or Other Neurological Disease ❑ yes ❑ no
- Do you have any other disease or problem? ❑ yes ❑ no
- If yes, please describe: ____

13. ARE YOU ALLERGIC, OR DO YOU REACT ADVERSELY TO:
- Local Anesthetics ("Novocaine") ❑ yes ❑ no
- Penicillin or Other Antibiotics ❑ yes ❑ no
- Sulfa Drugs ❑ yes ❑ no
- Barbiturates, Sedatives or Sleeping Pills ❑ yes ❑ no
- Aspirin, Acetaminophen or Ibuprofen ❑ yes ❑ no
- Codeine, Demerol or Other Narcotics ❑ yes ❑ no
- Reaction to Metals ❑ yes ❑ no
- Latex or Rubber Dam ❑ yes ❑ no
- Other: ____

14. WOMEN
- Are you taking contraceptives or hormones? ❑ yes ❑ no
- Are you pregnant? ❑ yes ❑ no
- If pregnant, what is expected delivery date? ______________________
- Are you nursing? ❑ yes ❑ no
- Have you reached menopause? ❑ yes ❑ no
- If menopausal, do you have symptoms? ___________________________
- Notes: ____

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Patient/Parent Signature: ____ Date: _____/_____/_____