

Bonita Family Dental

DENTAL HISTORY

This information is necessary for our files and will be kept CONFIDENTIAL.

Date _____

Patient Name _____

Last

First

Initial

What is the reason for your visit today?

Previous dentist name _____ Address _____ Phone _____

How often do you have a dental examination? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problem, pain or sensitivity now? YES NO

If yes, please describe: _____

Do you feel nervous about having dental treatment? YES NO

If yes, what is your biggest concern? _____

Have you ever had orthodontic treatment? YES NO

Have you ever had oral surgery? YES NO

Have you ever had periodontal (gum) treatment? YES NO

Have you ever had clicking or popping of jaw? YES NO

Have you ever had joint pain? YES NO

Have you ever had difficulty in opening or closing your mouth? YES NO

Have you ever had mouth odor or bad taste? YES NO

Have you ever had dry mouth? YES NO

Have you ever had food getting caught between your teeth? YES NO

Have you ever had an upsetting dental experience? YES NO

Do you clench or grind your teeth while awake or asleep? YES NO

Do you breathe through your mouth? YES NO

Do you have tired jaw, especially in the morning? YES NO

Do you smoke cigarettes or cigars? YES NO

If yes, how many a day? _____

Do you chew tobacco? YES NO

Are you satisfied with your teeth's appearance? YES NO

Would you like to have whiter teeth? YES NO

Is there anything else about dental treatment that you would like us to know? YES NO

If yes, please describe: _____

PLEASE COMPLETE BOTH SIDES

Bonita Family Dental

MEDICAL HISTORY

Patient Name _____

Are you in good general health? YES NO

Are you being treated for any illness now? YES NO

If yes, please describe: _____

Your physician's name _____ Address _____ Phone _____

Are you taking medication, drugs or pills now? YES NO

If yes, please describe: _____

Are you aware of having allergic reactions to any medication or substances? YES NO

If yes, please describe: _____

Have you been hospitalized during the past five years? YES NO

If yes, please describe: _____

Indicate which of the following you have had, or have at present

Heart disease, surgery, attack	YES	NO	Swollen ankles	YES	NO	Radiation therapy	YES	NO
Heart defect	YES	NO	Fainting, dizzy spells	YES	NO	Cancer	YES	NO
Artificial heart valve	YES	NO	Stroke	YES	NO	Chemotherapy	YES	NO
Heart murmur	YES	NO	Diet	YES	NO	Tumors	YES	NO
Congenital heart disease	YES	NO	Kidney trouble	YES	NO	Venereal disease	YES	NO
Mitral valve prolapse	YES	NO	Ulcers	YES	NO	A.I.D.S.	YES	NO
Rheumatic fever	YES	NO	Diabetes	YES	NO	H.I.V. positive	YES	NO
High blood pressure	YES	NO	Thyroid problems	YES	NO	Cold sores, fever blisters	YES	NO
Chest pain	YES	NO	Glaucoma	YES	NO	Blood transfusion	YES	NO
Heart pacemaker	YES	NO	Contact lenses	YES	NO	Hemophilia	YES	NO
Artificial joints	YES	NO	Hay fever	YES	NO	Sickle cell disease	YES	NO
TB, emphysema	YES	NO	Latex sensitivity	YES	NO	Bruise easily	YES	NO
Chronic cough	YES	NO	Allergies or hives	YES	NO	Liver disease	YES	NO
Asthma	YES	NO	Sinus trouble	YES	NO	Yellow jaundice	YES	NO
Arthritis, rheumatism	YES	NO	Psychiatric, psychological care	YES	NO	Epilepsy, seizures	YES	NO
Cortisone medication	YES	NO	Hepatitis	YES	NO			
Recreational drugs	YES	NO	If yes, how much?	_____				
Alcohol	YES	NO	If yes, how much?	_____				

Have you lost or gained more than 10 pounds in the past year? YES NO

Do you have or have you had any disease, condition or problem not listed? YES NO

If yes, please describe: _____

Women

Are you pregnant?..... YES NO _____ months Are you nursing?..... YES NO Are you taking birth control?..... YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature of Patient (Parent if Minor) _____ Date _____ Dr. _____

Recall Review

Signature of Patient (Parent if Minor) _____ Date _____ Dr. _____

Signature of Patient (Parent if Minor) _____ Date _____ Dr. _____

Signature of Patient (Parent if Minor) _____ Date _____ Dr. _____