

WHAT IS YOUR CHIEF CONCERN OR PRIMARY REASON FOR YOUR VISIT? _____

** Please circle Y (yes) or N (no) for the following questions, whichever applies. Your answers are for our records only and will be considered confidential.

MEDICAL HISTORY

- Y N Are you in good health? Y N Has there been any change in your general health within the last year?
- Y N Are you now under the care of a physician? For what? _____
 Name of Physician _____ Physician Phone # _____
- Y N Have you had a serious illness/hospitalization in the past 5 years? For what? _____
- Y N Are you taking any medication (incl. non-prescription)? _____

Do you have any of the following conditions?

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| <ul style="list-style-type: none"> Y N Allergies or drug reactions to: (Please check appropriate box) <ul style="list-style-type: none"> <input type="checkbox"/> Latex <input type="checkbox"/> Nickel or other metals <input type="checkbox"/> Penicillin or other antibiotics <input type="checkbox"/> Aspirin, Ibuprofen, Tylenol <input type="checkbox"/> Local anesthetics <input type="checkbox"/> Other _____ Y N Respiratory problems, emphysema Y N Asthma or hay fever Y N Sinus trouble Y N Diabetes Y N Tuberculosis Y N Hepatitis, jaundice or liver disease Y N AIDS, HIV+ infection or exposed to HIV Y N Mental health problem or nervous disorder Y N Fainting spells or seizures Y N Do you have any disease, condition or problem not listed above that you think we should know about or may be relevant to your treatment in our office? If so, please explain _____ | <ul style="list-style-type: none"> Y N Blood disorder such as anemia or abnormal bleeding Y N Cardiovascular disease (heart trouble, attack, angina, high blood pressure, arteriosclerosis, stroke) Y N Damaged or artificial heart valves, including heart murmur or rheumatic heart disease Y N Arthritis or joint problems or artificial joints/limbs Y N Require antibiotic pre-medication before dental visits? Y N Trauma to face or jaw Y N Vision, hearing or speech difficulty Y N Aphthous Ulcers ("Canker Sores") Y N Cold Sores / Fever Blisters Y N Females: Are you or could you be pregnant? |
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DENTAL HISTORY Name of dentist _____ Date of last dental exam / cleaning _____

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| <ul style="list-style-type: none"> Y N Chipped or injured permanent teeth Y N Prolonged tooth sensitivity to hot or cold Y N Bleeding gums or bad taste/mouth odor Y N Jaw fractures, cysts, mouth infections Y N Loose or shifting teeth Y N Have you had a negative dental experience? Y N Is all dental work completed at this time? | <ul style="list-style-type: none"> Y N Thumb or finger sucking habit Y N Mouth breathing habit or snoring troubles Y N Abnormal swallowing (tongue thrust) Y N Previous orthodontic treatment or retainer
What / When? _____ Y N Previous periodontal (gum) treatment
What / When? _____ |
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T.M.J. (TEMPORO-MANDIBULAR JOINT) HISTORY

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| <ul style="list-style-type: none"> Y N Have you ever been examined for TMJ problems? Y N Do you have a history or been treated for TMJ problems? Y N Do you have difficulty chewing or opening your mouth? Y N Does your bite feel uncomfortable or unusual? Y N Do you clench or grind your teeth? | <ul style="list-style-type: none"> Y N Do you have pain in your jaw joints? Y N Do you have pain or soreness in your jaw muscles? Y N Do you notice clicking or popping in your jaw joints? Y N Has your jaw ever locked? Y N Do you have frequent headaches? |
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**I certify that I have read and understand the above. I acknowledge that I have completed this form to my best knowledge, and that my questions have been answered to my satisfaction. I will not hold Dr. Davis or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes later to this history record or medical or dental status, I will inform the practice.

Signature of Patient (or Parent/Guardian of Minor) _____ Date _____

Update Signature _____ Date _____ Update Signature _____ Date _____