Dental Health History

Silver Creek Dental & Vision Care

Name _____ _____ _____ **Date of Birth** ____-____-_____

Last **First** **Middle**

Height _____ **Weight** _____ **Gender** ____ **SSN#** _____-_____-_____

Emergency Contact _____ **Relationship** _____

Cell Phone _____-_____-_____ **Home Phone** _____-_____-_____

Do you have any of the following diseases or problems?	**Yes**	**No**	**DK**
Active tuberculosis			
Persistent cough more than 3 week duration			
Cough with blood			
Been exposed to anyone with tuberculosis			

If you answer yes to to any of the above items, please stop and return this form to the receptionist.

Dental Information **DK = Don't know**	**Yes**	**No**	**DK**
Do your gums bleed when you brush or floss?			
Are your teeth sensitive to cold, hot, sweets or pressure?			
Do you have mouth dry?			
Have you had any periodontal (gum) treatment?			
Have you ever had orthodontic (braces) treatment?			
Have you had any problems associated with previous dental treatment?			
Is your home water supply fluoridated?			
Do you drink bottled or filtered water?			
Do you have earache or neck pain?			
Do you have any clicking, popping or discomfort in the jaw?			
Do you brux or grind your teeth?			
Do you have sores or ulcers in your mouth?			
Do you wear dentures or partials?			
Do you participate in active recreational activities?			
Have you ever had a serious injury to your head or mouth?			

Date of your last dental exam _____

Treatment done _____

Date of last dental x-rays _____

Reason for your dental visit today _____

How do you fell about you smile _____

Medical Information	Yes	No	DK
Are you under the care of a physician?			

Physician Name _____ Phone _____-_____-_____

Address _____ _____ _____ _____
City State Zip

Date of last physical exam _____

	Yes	No	DK
Are you in good health?			
Has there been any change in your general health within the past year?			
If yes, what is being treated?			
Have you had a serious illness, operation or been hospitalized in the past 5 years?			
If yes, what was the illness?			
Are you taking or have you recently taken any prescription or over the counter medicine(s)? Please list all, including supplements below			

Name	Dose	Frequency	Purpose

	Yes	**No**	**DK**
Do you wear contact lenses?			
Have you had an orthopedic total joint (hip, knee, elbow, and finger) replacement?			
If yes, date Any complications?			
Are you taking antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, or Prolia) for osteoporosis or Paget's disease?			
Since 2001, have you been treated with an antiresorptive agent (like Aredia, Zometa, or XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			
Treatment start date			
Do you use controlled substances (drugs)?			
Do you use tobacco (smoking, snuff, chew or bidis)?			
If yes, are you interested in stopping?			
Do you drink alcoholic beverages?			
If yes, how much alcohol did you drink in the last 24 hours?			
If yes, how much do you typically drink in a week?			

Women Only	Yes	No	DK
Are you pregnant?			
If yes, how many weeks? Which trimester?			
Are you taking birth control pills or hormonal replacement?			
Are you nursing?			

Allergies	Yes	No	DK
Local anesthetics			
Aspirin			
Penicillin or other antibiotics			
Barbiturates, sedatives, or sleeping pills			
Sulfa drugs			
Codeine or other narcotics			
Metals			
Latex (rubber)			
Iodine			
Hay fever/seasonal			
Animals			
Food			
Other			

Diseases or Problems	Yes	No	DK
Artificial (prosthetic) heart valve			
Previous infective endocarditis			
Damaged valves in transplanted heart			
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD			
Repaired (completely) in last 6 months			
Repaired CHD with residual defects			
Cardiovascular disease			
Angina			
Arteriosclerosis			
Congestive heart failure			
Damaged heart valves			
Heart attack			
Heart murmur			
Low blood pressure			
High blood pressure			
heart defects			
Mitral valve prolapse			
Pacemaker			
Rheumatic fever			
Rheumatic heart disease			
Abnormal bleeding			
Anemia			
Blood transfusion If yes, date			
Hemophilia			
AIDS or HIV infection			
Arthritis			
Autoimmune disease			
Rheumatoid arthritis			

Systemic lupus erythematosus			
Asthma			
Bronchitis			
Emphysema			
Sinus trouble			
Tuberculosis			
Cancer/Chemotherapy/Radiation treatment			
Chest pain upon exertion			
Chronic pain			
Diabetes Type			
Eating disorder			
Malnutrition			
Gastrointestinal disease			
G.E. Reflux/Persistent heartburn			
Ulcers			
Thyroid problems			
Stroke			
Glaucoma			
Hepatitis, jaundice or liver disease			
Epilepsy			
Fainting spells or seizures			
Neurological disorders If yes, specify			
Sleep disorder			
Do you snore?			
Mental health disorders If yes, specify			
Recurrent infections Type of infection			
Kidney problems			
Night sweats			
Osteoporosis			
Persistent swollen glands in neck			
Severe headaches/migraines			
Severe or rapid weight loss			
Sexually transmitted disease			
Excessive urination			

	Yes	**No**	**DK**
Do you have any disease, condition, or problem not listed above that you think I should know about?			
Please explain:			

Signature of Patient/Legal Guardian _____

Guardian Name & Relationship _____

Date _____