DENTAL HISTORY
(PLEASE ANSWER ALL QUESTIONS)

	Yes	No
Bad breath		
Bleeding gums		
Blister on lips or mouth		
Burning sensation tongue		
Chew on one side of mouth		
Cigarette, pipe or cigar smoking		
Clicking or popping jaw		
Dry mouth		
Finger nail biting		
Food collection between teeth		
Foreign objects		
Grinding teeth		
Gums swollen or tender		

	Yes	No
Jaw pain or tiredness		
Lip or cheek biting		
Loose teeth or broken filling		
Mouth breathing		
Mouth pain, brushing		
Orthodontic treatment		
Pain around ear		
Periodontal treatment		
Sensitivity to cold		
Sensitivity to heat		
Sensitivity to sweets		
Sensitivity when biting		
Sores or growth in your mouth		

Date last dental visit? _____
Date last date last x-ray? _____
Have you ever had unfavorable dental visit? ___
_____

Do you or have you any dental disease problem or condition that has not been been mentioned? Please explain. _____
_____

Have you ever been instructed in the care of your gum? _____

MEDICAL HISTORY

	YES	NO	Head or neck injury					
AIDS/HIV			Glaucoma			Scarlet fever		
Anemia			Headaches			Sinus trouble		
Arthritis			Heart murmur			Skin rash		
Artificial heart valves			Chemical dependency			Nervous problems		
Artificial joints			Heart problem			Special diet		
Asthma			Hepatitis _____			Stroke		
Back problems			Herpes			Swollen feet		
Blood disease			Jaundice			Swollen ankles		
Fainting or Dizziness			Tumor or growth on head or neck			Swollen neck glands		
Chemotherapy			Kidney disease			Thyroid problem		
Congenital heart lesions			High blood pressure			Radiation treatment		
Cortisone treatment			Low blood pressure			Respiratory disease		
Cough			Liver disease			Tonsillitis		
Diabetes			Pacemaker			Jaw pain		
Emphysema			Pressure in ears			Migraines		
Excessive bleeding			Mitral valve prolapse			Shortness of breath		
Epilepsy			Psychiatric care			Ulcer		
Cancer			Rheumatic fever			Venereal disease		

MEDICAL QUESTIONARE
(PLEASE ANSWER ALL QUESTIONS)

Are you in good health? _____
Have you ever been hospitalized? _____
If so, what was the problem? _____
_____
Are you pregnant? _____
If so, how many months? _____
Are you nursing? _____
Taking birth control? _____
List any medication you are currently
Taking? _____
_____
_____
Pharmacy name: _____
Phone #: _____
List any drugs or chemicals you are
Sensitive to: _____
_____
Allergies: _____
_____
Allergic to latex? _____
Do you snore? _____

Date last examination? _____
Do you wear cardiac pacemaker? _____
Are you under the care of a physician? ____
Physician's name? _____
If so, for what? _____
_____
Dou you have any other disease, problem or
condition that you think the doctor should
know about? _____
_____
_____
History of surgery major/minor and year?
_____
_____
_____
Do need to take any pre-medication? _____
If, so what is? _____
Have you had Chiropractic care? _____
If so, for what? _____
Rubber dam _____
_____

Do you take Fen-phen or Redux, Fosamax or Fosamax Plus D? _____

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TRESTMENT AS MAYBE NECESSARY FOR PROPER DENTAL CARE. I ATTEST TO THE ACCURACY OF THE INFORMATION IN THIS FORM.

Patient's Name _____ Date: _____

Patient or Guardian's signature_____ Date: _____

Dr. Terecita L. Dean DDS, FGD, NMD_____ Date: _____

Updated _____ By: _____
Updated _____ By: _____
Updated _____ By: _____