Patient Dental History 2018

NAME: ____ **DATE:** ________________________

Is there any change in your general health? □ Yes □ No ____

Any change in medications? □ Yes □ No (*Please list or give us your updated medication list to copy.)*

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Do you require antibiotics (pre-medication) before dental treatment? □ Yes □ No

Does anyone in your family have oral cancer? □ Yes □ No ____

Are you happy with your smile? □ Yes □ No ____

Would you like teeth whitening? □ Yes □ No **Invisalign® teeth straightening? □ Yes □ No**

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Oral Health: Use this checklist as a guide and mark ALL that apply to you today.

	anxiety/fearful/feeling scared		loose tooth/teeth
	bad breath/halitosis		lump
	bleeding in your mouth		receding gums
	blisters/sores/lesions		sensitivity (i.e. hot/cold)
	coating on the tongue		sinus pain
	dry mouth/sticky feeling in mouth		soreness/tenderness
	infection/pus		swelling/inflammation
	injury/trauma		taste/change in or loss of
	jaw joint pain/popping/pressure		white area

Standard Infection Control: Use this checklist as a guide and mark ALL that apply to you today.

	Flu-Like Symptoms		Recent trips out of the United States
	Recent Blood transfusion		Recurring fevers
	Frequent, forceful coughing		Open skin sores, abrasions