Sydney Walters DMD

Patient name: *Birth date*

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you having any dental pain, or do you have any sensitive areas in your mouth? o Yes o No
if yes_____

Have you had problems with previous dental treatment? o Yes o No

if yes_____

Are you apprehensive about dental treatment? o Yes o No if yes_____

Has anyone done anything that made dental treatment better for you? o Yes o No

if yes_____

Date of last dental treatment and dentists name? _____

Physicians name and date of last physical? _____

Have you ever taken premedication for a dental procedure? o Yes o No if yes_____

Do you have a night guard? o Yes o No

Have you ever had a deep cleaning? When? o Yes o No

if yes_____

Do your gums bleed easily? o Yes o No

Are you satisfied with the appearance of your teeth? o Yes o No

Whom may we thank for referring you to our office? _____

Are you taking any medications pills or drugs? Please list them.

_____

Have you ever been hospitalized or had a major operation? o Yes o No

if yes_____

Have you ever taken Fosamax Boniva Actonel or any other medications containing bisphosphonates?
o Yes o No

Do you use controlled substances? o Yes o No if yes_____

Do you vape or smoke anything? o Yes o No if yes_____

Have you ever had a reaction to local anesthetic? o Yes o No

Women : Are you

Pregnant or trying to become pregnant? o Yes o No Nursing? o Yes o No Taking oral contraceptives? o Yes o No

Are you allergic to any of the following? o Aspirin o Latex o Local Anesthetics o Codeine

o Sulfa Drugs o acrylic o Sulfites o Penicillin o Metals

Any other allergies?

_____

Have you had or ever had any of the following

Aids/HIV o Yes o No	Alzheimer's o Yes o No	Diabetes o Yes o No
Herpes o Yes o No	High Blood Pressure o Yes o No	Epilepsy or seizures o Yes o No
Hives Rash o Yes o No	Artificial Joint o Yes o No	Asthma o Yes o No
GI/ Stomach problems o Yes o No	Breathing problems o Yes o No	Headaches o Yes o No
Lung Disease o Yes o No	Thyroid Disease o Yes o No	Chest Pain o Yes o No
Osteoporosis o Yes o No	Tuberculosis o Yes o No	Heart Murmur o Yes o No
Heart Disease o Yes o No	Heart Pacemaker o Yes o No	Acid Reflux o Yes o No
Cancer o Yes o No	Heart Attack o Yes o No	Pain in Jaw Joint o Yes o No
Hepatitis B or C Yes o No	High Cholesterol o Yes o No	Kidney Problems o Yes o No

Have you ever had any serious illnesses not listed above? o Yes o No

if yes_____

Do you have any conditions you feel we should be aware of? o Yes o No

if yes_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. My responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian DATE _____

X _____