Fox Valley Dental Care

Health/Dental History (please print)

PATIENT NAME:_____ DATE: _____DR._____

Dental History

Do you have a specific dental problem? Describe. _____	Yes	No
Do your gums ever bleed?_____	Yes	No
Do you brush and floss on a routine basis?_____	Yes	No
Do you feel nervous about having dental treatment? _____	Yes	No
Do you want to keep your remaining teeth?_____	Yes	No
Does your jaw click?_____	Yes	No
Are you comfortable with the appearance of your smile? _____	Yes	No

If not, what would you change? ❑color ❑shape ❑alignment
Who referred you to our office? _____
When was your last visit to a dentist? _____
Name of last dentist _____

Medical History

Medical doctor's name_____

Are you under a doctor's care now? Why? _____	Yes	No
Are you taking any medications, pills, or drugs? What? _____	Yes	No
Are you allergic to any medications or substances? Penicillin? What? _____	Yes	No
Are you pregnant? _____	Yes	No

If you are taking oral contraceptives, talk to dentist about "notice to patient"
Please circle if you have had any of the following:

Heart Trouble	Chest Pain	Asthma	Cancer	Psychiatric Care
High Blood Pressure	Shortness of Breath	Hay Fever	X-ray or Cobalt Tmt.	Drug Addiction
Low Blood Pressure	Swelling of Feet/Ankles	Sinus Trouble	Chemo/Radiation	Hemophilia
Fainting or Dizziness	Emphysema	Arthritis/Gout	AIDS/HIV	Allergies
Rheumatic Fever	Stroke	Frequent Cough	Rheumatism	Venereal Disease
Artificial Heart Valve	Diabetes	Tuberculosis	Pain in Joints	Cold Sores
Heart Pacemaker	Artificial Joints/Hips	Hepatitis A (infec.)	Epilepsy or Seizures	Fever Blisters
Heart Surgery	Kidney Trouble	Hepatitis B (serum)	Cortisone Medicine	Herpes
Blood Disease	Ulcers	Yellow Jaundice	Nervousness	Bruise Easily
Anemia	Smoker	Sickle Cell Anemia		

X _____ patient signature (parent or guardian)

Medical Updates

DATE	NO CHANGE	PATIENT SIGNATURE	DR. REVIEWED