DENTAL HISTORY

Chief reason for today's visit: _____

Approximate date of your last dental visit: _____

Please check all that apply:

__ Bad breath	__ Lip or cheek biting	__ Smoker
__ Bleeding gums	__ Loose teeth	__ Ice chewing
__ Broken fillings	__ Mouth breathing	__ Heartburn
__ Fingernail biting	__ Sensitivity to cold	__ Gastric reflux
__ Jaw pain	__ Sensitivity to hot	__ **Latex allergy**
__ Pain when biting	__ Chewing tobacco	

Have you ever had or been diagnosed with a problem in either jaw joint (TMJ)? Y ___ N ___

Does your jaw joint click, pop, or make noise when you open or close? Y ___ N ___

Do you have tenderness in your jaw joint when you open, close, or chew? Y ___ N ___

Has your jaw ever locked or closed? Y ___ N ___

Do you have frequent headaches? Y ___ N ___

Do you clench or grind your teeth, or ever been told you do? Y ___ N ___

Do you snore? Y ___ N ___

Have you ever been diagnosed or suspected of sleep apnea? Y ___ N ___

How much **soda, tea, or juice** do you drink on a daily basis?
_____

Have you ever had a bad dental experience? Y ___ N ___

If yes, please explain _____

Have you ever had tooth whitening performed? Y ___ N ___

If so, would you be interested? Y ___ N ___

MEDICAL HISTORY

Physician's Name/Group Name _____ Date of last check-up _____

Have you ever taken any group of drugs referred to as "fen-phen"? These include combinations of Adipex, Fastin (phentermine), Ionimin, Pondmin (fenfluramine), and Redux (dexfenfluramine)? Y ___ N ____

Have you ever taken any of the following group of drugs referred to as "bisphosphonates"? These include **Oral** forms of Fosamax, Boniva, Actonel, Aredia, and **Intravenous** Zometa? Y ___ N ___

Do you have a history of a congenital heart defect or artificial heart valve? Y ___ N ___

Do you have an artificial joint? Where and when placed _____ Y ___ N ___

Have you ever had any of the following:

__ AIDS/HIV	__ Diabetes (Type I or II)	__ Liver disease
__ Anemia	__ Epilepsy	__ Mitral valve defect
__ Artificial joints	__ Fainting/dizziness	__ Osteoporosis
__ Asthma	__ Fibromyalgia	__ Rheumatic fever
__ Back pain	__ Heart murmur	__ Scarlet fever
__ Bleeding abnormally	__ Hepatitis (Type A, B, C)	__ Sinus infection
__ Cancer	__ Herpes	__ Stroke
__ Chemical dependency	__ High Blood Pressure	__ Thyroid defects
__ Chemotherapy	__ Irritable bowel syndrome (IBS)	__ Tuberculosis
__ Cortisone treatments	__ Kidney disease	__ Radiation therapy

Are there any medical conditions not listed above that you are aware of? _____

_____

List **medications** currently taking (prescribed and over the counter) _____

_____

_____

List all **drug allergies** _____

_____

**What is your pharmacy name? _____