ADVANCE BLVD DENTAL HEALTH GROUP

Dental History

1. Reason for today's visit: Exam: ☐ Cleaning: ☐ Emergency: ☐ Other: _____
2. Is there a problem you would like taken care of as soon as possible? Yes: ☐ No: ☐
   If yes please explain: _____
3. Do you have pain in any part of your mouth? ☐ ☐
4. Do your gums bleed? ☐ ☐
5. Have you ever noticed any loose teeth or have any of your teeth shifted? ☐ ☐
6. Are any of your teeth sensitive to heat/cold/sweet/pressure? ☐ ☐
7. Have you been advised to take antibiotics before a dental appointment? ☐ ☐
8. Do you have pain or noise from your jaw joints? ☐ ☐
9. Do you clench or grind your teeth during the day or night? ☐ ☐
10. Have you ever had problems with dental treatments? ☐ ☐
11. Have you ever had a problem with local anaesthesia (freezing)? ☐ ☐
12. Are you dissatisfied with the appearance of your teeth? ☐ ☐
13. Do you have any questions or concerns? ☐ ☐
14. Are you or have you ever been treated by a dental specialist? ☐ ☐

Former dentist: _____ Last dental visit: _____

Medical History

Physician's Name: _____ Phone: _____

1. Are you presently under the care of a physician? Yes: ☐ No: ☐ If so explain: _____
2. Approximate date of last medical appointment? Reason: _____
3. Have you recently or are you presently taking ANY medicines or drugs? Yes: ☐ No: ☐
   Please list:
   _____
4. Have you experienced any unusual reaction to any of the following? (if yes, please check)
   - ☐ Local Anaesthetics (freezing)
   - ☐ Aspirin
   - ☐ Nitrous Oxide
   - ☐ Antibiotics - Penicillin, Sulfonamides, Other
   - ☐ Codeine
   - ☐ Other
5. Have you ever been advised against taking any specific type of medication? Yes: ☐ No: ☐
6. Do you suffer from any allergies to? (if yes, please check)
   - ☐ Latex ☐ Any Metals ☐ Mercury ☐ Other
   - ☐ Nickel ☐ Foods ☐ Hayfever Explain: _____
7. Do you smoke? Yes: ☐ No: ☐ # per day _____ # of years _____ Quit how long ago? _____

Do you have or have you had any of the following? (if yes, please check)

☐ Chest Pains	☐ Malignant Hyperthermia	☐ Jaundice	☐ Joint Replacement
☐ Heart Attack	☐ Tendency to Bruise Easily	☐ Hepatitis A, B, C	☐ Organ Transplants
☐ Shortness of Breath	☐ Prolonged Bleeding	☐ Liver Disease	☐ Medical Implants
☐ Artificial Heart Valve	☐ HIV Positive (AIDS)	☐ Recurring Kidney Infection	☐ Epilepsy / Seizures
☐ Swelling of Ankles	☐ Sinusitis	☐ Kidney Stones	☐ Drug/Alcohol Addiction
☐ High / Low Blood Pressure	☐ Asthma	☐ Food Intolerances	☐ Cancer
☐ Heart Murmur	☐ Bronchitis	☐ Ulcers	☐ Radiation Therapy
☐ Heart Disease	☐ Tuberculosis	☐ Diabetes	☐ Other
☐ Rheumatic Fever	☐ Cirrhosis	☐ Thyroid Problems	Explain _____

Women: Are you pregnant or think you might be? Yes: ☐ No: ☐ Number of months? _____
Are you taking birth control pills. ☐ ☐

Please list all surgeries / hospitalizations / serious illnesses and approximately when they occurred:

_____

Is there anything else about your health that we should be aware of?

_____