



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Chief Complaint** (Why are you seeking dental care?)

\_\_\_\_\_

**Current State of Health**

Are you currently under the care of a physician..... No Yes  
 When were you last seen by a physician? \_\_\_\_\_

**Please list your family doctor and any specialists you see at least once a year** (Please print)

Name	Address	Phone#	Name of Specialist

**Medical History**

1. Do you have or have you had any of the following?
  - a. rheumatic fever, rheumatic heart disease, bacterial endocarditis..... No Yes
  - b. heart murmur or mitral valve prolapse..... No Yes
  - c. heart disease or heart attach..... No Yes
  - d. artificial heart valve..... No Yes
  - e. irregular heart beat..... No Yes
  - f. pacemaker/defibrillator..... No Yes
  - g. high blood pressure..... No Yes
  - h. angina (chest pains)..... No Yes
  - i. stroke..... No Yes
  - j. artificial joint(s) (Circle all that apply)..... No Yes
 

Hip	Knee	Ankle	Shoulder
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Date(s) placed: \_\_\_\_\_

Have you had any problems with the artificial joint(s), including revisions or infections? ..... No Yes
  - k. other artificial implants or devices..... No Yes
  - l. muscle or joint disease..... No Yes
  - m. skin diseases..... No Yes
  - n. hepatitis or other liver disease..... No Yes
  - o. stomach or intestinal disease..... No Yes
  - p. tuberculosis..... No Yes
  - q. asthma or other lung disease..... No Yes
  - r. bleeding problem, anemia, or other blood disease..... No Yes
  - s. kidney disease..... No Yes
  - t. nervous system disease or seizures..... No Yes
  - u. diabetes (sugar)..... No Yes
  - v. thyroid disease..... No Yes
  - w. Immunosuppressive condition (Circle all that apply)..... No Yes
 

Steroid Therapy	Radiation or Cancer Therapy	Rheumatoid Arthritis
Organ Transplant	SLE (Lupus)	No Spleen function

2. Do you have any disease, condition, or problem not listed above?..... No Yes
3. Have you ever been hospitalized or had surgery?..... No Yes
4. Have you had an allergic reaction to drugs or latex?..... No Yes  
(Circle all that apply) Latex, Penicillin, Aspirin, Codeine, Local Anesthetics, Other \_\_\_\_\_
5. Do you have any undiagnosed symptoms? ..... No Yes
6. (Women) Are you or could you be pregnant? \_\_\_\_\_ Are you nursing? \_\_\_\_\_
7. Do you have substance abuse problems (active or recovering, drugs and/or alcohol)?..... No Yes
8. Do you use smokeless tobacco? ..... No Yes
9. Do you smoke? ..... No Yes
10. Do you regularly take herbal medicines or dietary supplements?..... No Yes  
Specifically, do you take (circle all that apply): These are known to affect dental treatment.  

Echinacea	Garlic	Ginger	Kava	Valerian
Feverfew	Gingko	Ginseng	St. John's Wort	Vitamin E

**Dental History**

1. Do you have regular dental check-ups? \_\_\_\_\_ Date of last exam \_\_\_\_\_
2. Have you had any trouble associated with previous dental treatment..... No Yes
3. Have you noticed any lumps or sores in your mouth? ..... No Yes
4. Do your gums bleed when you brush your teeth?..... No Yes
5. Have you ever injured your face or jaws?..... No Yes
6. Do you suffer from pain in the mouth, face, eyes, neck or throat?..... No Yes
7. Are you unhappy with the appearance of your teeth?..... No Yes
8. Do you want to save your teeth?..... No Yes
9. Has fear kept you from seeking dental treatment?..... No Yes
10. Are you allergic to any metals or dental materials?..... No Yes
11. Circle the types of dental treatment you have experienced:  

Orthodontics (braces)	Dentures	Root canal treatment	Oral Surgery
Periodontal (gum) treatment		Implants	TMJ treatment

**Please complete the enclosed medication list, and then sign below:**

Dentistry With A Woman's Touch, P.S. requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside of Dentistry With A Woman's Touch, P.A. will be provided this information unless properly authorized by you or required by law. Failure to provide the requested information will limit our ability to access your needs and may result in Dentistry With A Woman's Touch, P.A. being unable to accept you as a patient.

By signing below, you agree that the information given is accurate and that you will notify Dentistry With A Woman's Touch, P.a. at subsequent appointment if there are any changes in your health.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

(or) Patient's representative \_\_\_\_\_

Relationship to patient \_\_\_\_\_

