ARTISAN DENTAL
Cosmetic, Sedation and Implant Dentistry

Dental and Medical History

What is the reason for your visit today?

_____

Date of Last Dental Visit _____

Have you had previous orthodontic treatment? ☐Yes ☐No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain:

_____

Have there been any injuries to your face, mouth or teeth?
☐Yes ☐No If yes, please explain:

_____

Are you presently in any dental pain?
☐Yes ☐No If yes, please explain:

_____

Do your gums bleed when you brush your teeth?

☐Yes ☐No

Is any part of your mouth sensitive to temperature or pressure? ☐Yes ☐No

Do your teeth or jaws ever feel uncomfortable, or make any clicking or popping noises? ☐Yes ☐No

Do you clench your teeth during the day? ☐Yes ☐No

Have you ever been told that you grind your teeth?

☐Yes ☐No

Have you ever experienced chronic ringing in your ears?

☐Yes ☐No

Do you have 'tension' headaches? ☐Yes ☐No

Do you have blisters or sores on your lips and/or in your mouth? ☐Yes ☐No

Do you ever have a burning sensation on your tongue?

☐Yes ☐No

Do you smoke cigarettes, cigars, a pipe, etc. or use any tobacco product? ☐Yes ☐No

Do you consider yourself to be in good general health at this time? ☐Yes ☐No

Are you currently under the care of a physician?

☐Yes ☐No If yes, please what is being treated?:

_____

Name, location, and phone number of current physician:

_____

Are you currently taking any medications, vitamins, supplements?

☐Yes ☐No If yes, please describe:

_____

Have you ever taken the drug Phen-fen and/or Redux?

☐Yes ☐No If yes, when?:_____

Are you allergic to any medication including, but not limited to: Codeine, Penicillin, Tetracycline, Sulfa Drugs, Aspirin, or any other medication?

☐Yes ☐No If yes, please explain:

_____

Do you have any other allergies?

☐Yes ☐No If yes, please explain:

_____

Do you have a history or any major illness?

☐Yes ☐No If yes, please explain:

_____

Are you or have you ever taken Bisphosphonates for osteoporosis or cancer treatment?

☐Yes ☐No If yes, when?:_____

Have you ever been involved in a serious accident?

☐Yes ☐No If yes, please explain:

_____

Have you been admitted to a hospital or needed emergency care during the past 2 years?

☐Yes ☐No If yes, please explain:

_____

Women Only:

Are you pregnant, or is there any chance you may be?
☐Yes ☐No If yes, due date: _____

Are you nursing?
☐Yes ☐No

If you checked either of the above and need to describe it, please do so here:

_____

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Please check any of the following that you have had or currently have:

- ☐ Abnormal bleeding/Hemophilia
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints/Prosthesis
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Bone Disorders
- ☐ Chemical/Drug Dependency
- ☐ Chest Pain upon Exertion
- ☐ Circulatory Problems
- ☐ Congenital Heart Defect
- ☐ Cortisone Treatments
- ☐ Diabetes (Type I or II)
- ☐ Dizziness or Seizures
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy or Fainting
- ☐ Glaucoma
- ☐ Gastrointestinal Disease
- ☐ Headaches or Migraines
- ☐ Heart Problems, Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis/Liver Problems
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Problems
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Neurological Disorders
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker or Defibrillator
- ☐ Previous Infective Endocarditis
- ☐ Psychiatric Care
- ☐ Radiation/Chemotherapy
- ☐ Rapid Weight Loss/Gain
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Skin Rash
- ☐ Sinus Troubles
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Cancer
- ☐ Ulcer
- ☐ Venereal Disease

- Do you have any other disease, condition, or problem not listed above that you think we should know about?

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of Patient, Parent or Guardian