

Dr. Charles E. Stuart

Patient Name: _____ Date: _____

DENTAL HISTORY

Previous Dentist: _____ Date of Last Dental Exam: _____ Date of Last X-Rays: _____

- 1 Have there been any injuries to the face, mouth or teeth? Yes No
- 2 Have you had or do you presently have any of the following habits?
 Thumb or finger sucking Lip Biting Snoring
 Grinding of teeth at night Mouth breathing No
- 3 Have you been informed of any missing or extra permanent teeth? Yes No
- 4 Are you aware of sores, lumps or irritated areas in the mouth? Yes No
- 5 Have you or are you currently experiencing any mouth pain? Yes No
- 6 Have you every been treated for:
 Bad Bite TMJ Periodontal Disease
- 7 Do you have any speech problems? Yes No
- 8 Are you concerned about the appearance of your teeth? Yes No
- 9 Is there anything you would like to change about your smile? Yes No

If so, what? _____

- 10 What aspect of dental treatment are you most concerned with?
 Quality Cost Discomfort Time

11 Reason for today's visit:

- 12 Has an orthodontist been consulted previously? Yes No

Name of Dr.: _____ Date: _____

MEDICAL HISTORY

- 1 Is your general health good at this time? Yes No
- 2 Are you under the care of a physician at this time? Yes No

Name of Physician: _____ Date of last physical: _____

- 3 Are you taking any medication? Yes No
- 4 Are you taking aspirin or any blood thinners? Yes No
- 5 Are you allergic to any medication? (Penicillin, sulfa, etc.) Yes No

If yes, what: _____

- 6 Have you ever had a serious illness or been hospitalized? Yes No

Explain: _____

- 7 Have you had your tonsils and adenoids removed? Yes No Date: _____
- 8 Do you have any special problems not listed? Yes No

Explain: _____

MEDICAL HISTORY CONTINUED

9 Have you ever been advised by your previous dentist or a physician to take an antibiotic prior to any dental treatments? Yes No

If yes, antibiotic name and method: _____

10 What is your approximate height? _____

11 WOMEN:

Are you pregnant or considering pregnancy during the next 2 years Yes No

Are you nursing? Yes No

Are you currently taking medication for birth control Yes No

12 Do you have now or have you every had any of the following?

- | | |
|---|---|
| <p>Endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack (coronary) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Congenital Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Surgery Date: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood Disorders/Bleeding Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Inflammatory Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting Spells <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Prosthetic (artificial) Joint <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>X-Ray/Radiation (cancer) Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS OR H.I.V. Positive <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory Lung disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis (type?____) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Herpes (oral-cold sores) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychiatric Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Earaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaw Clicking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tonsilitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Allergies to Metal <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emotional Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|---|

Other: _____

I certify that the information given is correct and hereby give permission to take x-rays and any diagnostic tests needed. I also give permission to give this or any information to my insurance company if so requested about me.

Signature: _____ Date: _____
 (patient or parent of patient)