CHINA TOWNSHIP FAMILY DENTISTRY, P.C.
5013 St. Clair Highway China Twp., Michigan 48054 (810)329-6655

DENTAL HISTORY

Patient's Name_____D.O.B_____
Please circle the correct response: answer all questions. The following questions are for our records only and will be considered confidential information.

1. What is the reason for your dental visit?_____ Yes No Don't Know
2. Have you ever had any complications following dental treatment?_____ Yes No Don't Know
   If yes please explain_____
3. Are you concern about receiving dental treatment_____ Yes No Don't Know
4. Have you ever had a bad reaction to a local dental anesthetic?_____ Yes No Don't Know
5. Have you ever had a severe injury to your face, teeth or jaws?_____ Yes No Don't Know
6. Have you ever had surgery in your mouth or on your lips?_____ Yes No Don't Know
7. How many times a day do you brush your teeth?_____ _
8. Are your teeth sensitive to hot, cold or pressure?_____ Yes No Don't Know
9. Do you have bleeding gums_____ Yes No Don't Know
10. Do you have frequent or recurrent sores in your mouth?_____ Yes No Don't Know
11. Have you ever had periodontal treatment for your gums?_____ Yes No Don't Know
12. Have you ever had orthodontic treatment to straighten your teeth?_____ Yes No Don't Know
13. Have you had a recent tooth ache?_____ Yes No Don't Know
14. Do you have trouble chewing?_____ Yes No Don't Know
15. Do you clench or grind your teeth_____ Yes No Don't Know
16. Do you have any difficulty opening your mouth as wide as you would like?_____ Yes No Don't Know
17. Have you had any missing teeth replaced by a removable denture for fixed bridge?_____ Yes No Don't Know
18. Are you interested in more information about replacements?_____ Yes No Don't Know
19. Are you satisfied with the appearance of your teeth?_____ Yes No Don't Know
20. Do you have any further questions, concerns, or additional information?_____ Yes No Don't Know
    If yes, please specify:_____
21. If there was s simple and inexpensive way to whiten your teeth, would you be interested:_____ Yes No Don't Know
22. What is the name of your previous dentist?_____

HABITS

23. Do you now or have you ever used tobacco products?_____ Yes NO
24. How many alcohol drinks do you consume a day_____week_____month_____
25. Have you ever had a history of drug dependency?_____ Yes No Don't Know

MEDICAL HISTORY

CARDIOVASCULAR AND BLOOD DISORDERS

1. Rheumatic fever?_____ Yes No Don't Know
2. Hypertension (high blood pressure)_____ Yes No Don't Know
3. Heart attack. Irregular heart rate. Damaged heart valves or angina?_____ Yes No Don't Know
4. Stroke?_____ Yes No Don't Know
5. Heart mumur?_____ Yes No Don't Know
6. Chest pain or shortness of breath on exertion?_____ Yes No Don't Know
7. Do you bruise easily?_____ Yes No Don't Know
8. Are you excessively nervous?_____ Yes No Don't Know
9. Do you get tired easily?_____ Yes No Don't Know
10. Swollen ankles?_____ Yes No Don't Know
11. Blood disorders such as anemia or hemophilia?_____ Yes No Don't Know

ALLERGIES AND IMMUNE SYSTEM

13. Asthma or hay fever?_____ Yes No Don't Know
14. Hives or a skin rash?_____ Yes No Don't Know
15. Have you ever had a reaction to any drugs?_____ Yes No Don't Know
16. Do you have any allergies?_____ Yes No Don't Know
17. Are you immunosuppressed (subject to frequent infections)?_____ Yes No Don't Know
18. Have you been told you have AIDS ARC or an HIV positive test?_____ Yes No Don't Know
19. Do you have reason to believe you may have been exposed to the AIDS virus?_____ Yes No Don't Know

GASTROINTESTINAL

20. Do you vomit frequently?_____ Yes No Don't Know
21. Ulcers, stomach, or intestinal problems_____ Yes No Don't Know
22. Hepatitis (Jaundice) or liver disease?_____ Yes No Don't Know
23. Are there any foods you cannot eat?_____ Yes No Don't Know

RESPIRATORY

24. Persistent cough?_____ Yes No Don't Know
25. Respiratory disease?_____ Yes No Don't Know
26. Tuberculosis?_____ Yes No Don't Know
27. Sinus trouble?_____ Yes No Don't Know
28. Do you ever cough blood?_____ Yes No Don't Know

ENDOCRINE

29. Diabetes (high blood sugar)?_____ Yes No Don't Know
30. Frequent urination (six times/day). Kidney disease or dialysis?_____ Yes No Don't Know
31. Increase in thirst_____ Yes No Don't Know

CENTRAL NERVOUS SYSTEM

32. Tendency to faint. Have convulsions. Seizure or epilepsy?_____ Yes No Don't Know

MEDICATIONS

33. Are you taking ANY medications now?_____ Yes No Don't Know
    If yes, please list the prescription AND non-prescription.
    _____
    _____

EYE, EARS, NOSE, THROAT

34. Do you get frequent or severe headaches?_____ Yes No Don't Know
35. Have you ever had eye, ear, nose, or sinus problems_____ Yes No Don't Know
36. Do you have difficulty swallowing_____ Yes No Don't Know

GENERAL

37. Are you in good health?_____ Yes No Don't Know
38. Has there been any change in your general health in the last year?_____ Yes No Don't Know
39. Have you ever had an artificial joint replaced?_____ Yes No Don't Know
40. Arthritis (painful, swollen joints)?_____ Yes No Don't Know
41. Cancer, chemotherapy, or radiation therapy?_____ Yes No Don't Know
42. Have you lost weight without dieting in recent months?_____ Yes No Don't Know
43. Venereal disease (syphilis, gonorrhea, herpes or other)?_____ Yes No Don't Know
44. Have you ever had any blood transfusions?_____ Yes No Don't Know
45. Are you being treated by a physician now?_____ Yes No Don't Know
    If yes, for what condition?_____
46. Have you been examined by your physician within the last year?_____ Yes No Don't Know
47. Been hospitalized, had major surgery or been seriously hurt or ill?_____ Yes No Don't Know
48. Do you have any further question, concerns, or additional information?_____ Yes No Don't Know
    If yes, please specify_____
49. Are you pregnant?_____ Yes No Don't Know
50. Physician's name:_____
    Address_____

Date:_____Patient's Signature (parent, if minor)_____

Checked by Dr._____