tyson petersen. DOCTOR OF DENTAL SURGERY

Patient Name_____ Date_____

Primary reason for this dental appointment: ▢ Examination ▢ Emergency ▢ Consultation ▢Other_____

Dental History

Please Circle

Yes No Do you have dental examinations on a routine basis? _____

Yes No Do you Brush and Floss on a routine basis? _____

Yes No Do you want to keep your remaining teeth? _____

Yes No Do you have a specific dental problem? Describe_____

Yes No Do you have any problems with: ▢Snoring ▢Bad Breath ▢Sensitive Teeth _____

Yes No Do you think you have active decay or gum disease?_____

Yes No Do your gums ever bleed? Discuss_____

Yes No Is there anything about your smile you would like to change?_____

Yes No Does food catch between your teeth?_____ Any loose teeth?_____

Yes No Do you ever have clicking, popping or discomfort in the jaw joint? _____

Yes No Do you clench or grind your teeth? _____

Yes No Have your past experiences in a dental office kept you from regular checkups?_____

Yes No Do you smoke or chew tobacco?_____ Do you vape?_____

Yes No Are there any sores or growths in your mouth? Discuss_____

Yes No Date of last x-rays &/or dental exam:_____

Medical History

Yes No Do you have a history of Phen Fen use?_____

Yes No Are you under a physician's care now? Why?_____

Yes No Have you ever been hospitalized or had a major operation? Discuss_____

Yes No Have you ever had a serious injury to your head or neck? Discuss_____

Yes No Are you taking any medications, pills or drugs?_____

Yes No Are you on a special diet? Discuss _____

Are you allergic to any medications or substances? Please check box below:

▢Aspirin ▢Penicillin ▢Codeine ▢Acrylic ▢Metal ▢Latex Rubber ▢Sulfa ▢Local anesthetics ▢Other_____

Yes No Have you ever taken Fosamax, Actonel, Boniva, or other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? _____

Yes No **For Women**: Are you pregnant or trying to get pregnant?_____Due Date:_____

Do you have or have you ever had any of the following? ***Answer all questions by checking the appropriate box.***

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Bleeding Problems/Anemia	☐	☐	Chemotherapy	☐	☐	Arthritis/Gout	☐	☐
Heart/Murmur	☐	☐	Sickle Cell Disease	☐	☐	Stomach/Intestinal Disease	☐	☐	Artificial Joint	☐	☐
Irregular Heart Beat	☐	☐	Leukemia	☐	☐	Ulcers	☐	☐	AIDS	☐	☐
Angina/Chest Pain	☐	☐	Recent Blood Transfusion	☐	☐	Recent Weight Loss	☐	☐	HIV Positive	☐	☐
Heart Attack/ Failure	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Drug Addiction	☐	☐
Congenital Heart Disorder	☐	☐	Breathing Problem	☐	☐	Diabetes	☐	☐	Stroke	☐	☐
Mitral Valve Prolapse	☐	☐	Frequent Cough	☐	☐	Excessive Thirst	☐	☐	Convulsions	☐	☐
Scarlet Fever	☐	☐	Sinus Trouble	☐	☐	Hypoglycemia	☐	☐	Epilepsy or Seizures	☐	☐
Rheumatic Fever	☐	☐	Asthma	☐	☐	Liver Disease	☐	☐	Fainting or Dizziness	☐	☐
Artificial Heart Valve	☐	☐	Emphysema	☐	☐	Hepatitis A	☐	☐	Glaucoma	☐	☐
Heart Pacemaker	☐	☐	Tuberculosis	☐	☐	Hepatitis B	☐	☐	Nervousness	☐	☐
High Blood Pressure	☐	☐	Cancer or growths	☐	☐	Kidney Problems	☐	☐	Psychiatric Care	☐	☐
Low Blood Pressure	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Thyroid Disease	☐	☐	Alzheimer's Disease	☐	☐
									Cold Sores	☐	☐

Yes No Have you ever had any other serious illness not checked above? Discuss_____

NOTES:_____

_____

To the best of my knowledge, all of the preceding answers are correct. If i have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X_____ Date: _____

Patient Signature (Parent or Guardian)