

Del Dental Group

8035 W. Manchester Ave., Suite B
 Playa Del Rey, CA 90293
 310-822-8118

PATIENT HEALTH HISTORY					
PATIENT MEDICAL HISTORY					
Name:			Date of Birth:		
Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.					
	YES	NO		YES	NO
1. Are you in good health?			12. Have you ever taken Fen-Phen/Redux?		
2. Have there been any changes in your general health within the past year?			13. Do you use tobacco?		
3. Date of your last physical exam:			14. Do you or have you used controlled substances?		
4. Physician's Name Address Phone			15. Are you wearing contact lenses?		
5. Are you now under the care of a physician?			16. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?		
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain.			17. Do you have any disease, condition or problem not listed above that you think I should know about?		
7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking?					
8. Have you had any abnormal bleeding?			WOMEN ONLY		
9. Do you bruise easily?			18. Are you pregnant or think you may be pregnant?		
10. Have you ever required a blood transfusion?			19. Are you nursing?		
11. Have you had a recent weight loss?			20. Are you taking birth control pills?		
Are you allergic to or have you had any reactions to:					
	YES	NO		YES	NO
Local anesthetics like novocaine			Iodine		
Penicillin or other antibiotics			Any metals (e.g., nickel, mercury, etc.)		
Sulfa drugs			Latex or rubber		
Barbituates, sedatives or sleeping pills			Ibuprofen		
Aspirin			Iodine		
Codeine			Other (please list)		
Have you ever taken any of these medications?					
	YES	NO		YES	NO
Blood Thinners			Diet Medications		
Coumadin			Dexfenfluramine		
Warfarin			Fen-phen		
Levoxyl			Pondimin		
Synthroid			Redux		
Do you have or have you ever had the following:					

PATIENT HEALTH HISTORY

	YES	NO		YES	NO
Rheumatic heart disease or rheumatic fever			Joint replacement or implant		
Scarlet fever			Stomach ulcer		
Heart defect or heart murmur			Kidney trouble		
Heart trouble, heart attach, or angina			Tuberculosis		
Chest pain			Persistent cough		
Shortness of breath			Cough, persistent or bloody		
Pacemaker			Chemotherapy (cancer, leukemia)		
Heart surgery			Sexually transmitted disease		
High/low blood pressure			Epilepsy or seizures		
Congenital heart problem			Anemia		
Swelling of feet, ankles, hands			Glaucoma		
Hepatitis, jaundice or liver disease			Nervousness		
Stroke			Tonsillitis		
Sinus trouble			Tumors or Growths		
Lung or breathing problems			Mental health care		
Asthma or hay fever			Back problems		
Hives or skin rash			Chemical dependency		
Fainting or dizzy spells			Mitral valve prolapse		
Diabetes			Cortisone treatment		
AIDS or HIV infection			Cold sores/fever blisters		
Thyroid problems			Hypoglycemia		
Allergies			Eating disorders		
Arthritis or Rheumatism			Circulatory problems		
Emphysema			Kidney Disease		
Headaches			Liver Disease		
Jaundice			Psychiatric care		
Jaw Pain			Radiation Treatment		
Respiratory Disease			Scarlet Fever		
Sinus Trouble			Special Diet/Weight Loss		
Stroke			Swollen Neck Glands		
Ulcer			Tuberculosis		
Venereal Disease			Artificial Heart Valves		
Artificial Joints, screws, pins, etc			Bleeding abnormally with extractions or surgery		
Blood Disease			Congenital Heart Lesions		
Venereal Disease			Artificial Heart Valves		
	YES	NO		YES	NO

PATIENT DENTAL HISTORY

Reason for this visit.	
When was your last dental visit?	
What was done then?	

PATIENT HEALTH HISTORY

How often did you visit the dentist before then?			
Previous dentist (name and location).			
Have you had a complete series of dental films (x-rays) taken? When and where?			
How often do you brush your teeth?			
How often do you floss your teeth?			
Is your drinking water fluoridated?			
	YES	NO	
Do your gums bleed while brushing or flossing?			Do you clench or grind your teeth?
Are your teeth sensitive to hot or cold liquids/foods?			Do you bit your lips or cheeks frequently?
Are your teeth sensitive to sweet or sour liquids/foods?			Have you noticed any loosening of your teeth?
Do you feel pain to any of your teeth?			Does food tend to become caught between your teeth?
Do you have any sores or lumps in or near your mouth?			Have you ever had periodontal treatment (gums)?
Have you ever experienced any of the following problems in your jaw?			Ever worn a bite plate or other appliance
Clicking			Have you ever had any difficult extractions in the past?
Pain (joint, ear, side of face)			Have you ever had any prolonged bleeding following extractions?
Difficulty in opening or closing			Do you wear dentures or partials
Difficulty in chewing			If yes, date of placement
Do you have frequent headaches			Have you ever received oral hygiene instructions regarding the care of your teeth and gums?
Bad Breath			Blisters on lips or mouth
Burning Sensation on Tongue			Cigarette, pipe, or cigar smoking
Dry Mouth			Fingernail Biting
Foreign objects in Mouth			Gums swollen or tender
Jaw Pain or tiredness			Mouth breathing
Orthodontic treatment			Periodontal treatment

If you could change anything about your smile, what would you change?

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AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent/guardian if minor.	Date:

Doctor's Comments:

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Signature of doctor.	Date: