PATIENT NAME _____ BIRTH DATE_____ DATE _____

MEDICAL AND DENTAL HISTORY

When was the last time your were teeth cleaned? _____ Do you now or have you ever worn orthodontic appliances? ☐yes ☐no.
How often do you see a dentist? ☐occasionally, or only when I have a problem ☐every 2 or 3 years ☐yearly ☐twice a year ☐more than twice a year
Would you be disturbed if you lost your teeth and had to wear dentures? ☐yes ☐no
Do you experience severe apprehension about dental treatment? ☐yes ☐no Have you had any injury to your teeth, jaws, or face? ☐yes ☐no
Do you floss at least twice a week? ☐yes ☐no Do you brush ☐occasionally ☐2 to 4 times a week ☐daily ☐twice daily ☐3 times a day ☐after meals?
What type of toothbrush do you use? ☐manual ☐electric What brand? _____ Its bristles are ☐soft ☐medium ☐hard

PLACE A CHECK IN THE BOX TO THE LEFT IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR CONDITIONS.

☐Bleeding gums	☐Sore gums	☐Frequent headaches	☐Feeling teeth do not fit
☐Swelling or abscess in gums	☐Sensitive teeth	☐Tired jaws	☐Food packs between teeth
☐Trench mouth (NUG)	☐Shifting teeth	☐Pain in joints (TMJ)	☐Floss catches between teeth
☐Receding gum line	☐Loose teeth	☐Clenching/grinding teeth	☐Unhappy with appearance of teeth
☐Bad taste or odor	☐Increased spaces between teeth	☐Clicking/popping joints	☐Allergic reaction to metals in jewelry

PLACE A CHECK IN THE BOX TO THE LEFT OF ANY CONDITION THAT YOU HAVE HAD OR MAY HAVE NOW.

☐Prolonged bleeding	☐Constant thirst or dry mouth	☐Glaucoma
☐Rheumatic heart disease (RHD)	☐Repeated infections, difficult healing	☐Kidney disease
☐Heart attack (MI)	☐Yeast infections	☐Venereal disease
☐Damaged or artificial heart valve	☐Endocrine disease	☐Alcohol or drug dependence at any time
☐Heart murmur	☐Hormone therapy	☐AIDS, AIDS related condition, tested HIV positive
☐High blood pressure	☐Cortisone or steroid therapy	☐Rash or drug reaction
☐Heart rhythm problems	☐Thyroid problem	☐Ever took Fen-Phen diet medications
☐Other heart condition_____	☐Hepatitis of any type, jaundice, liver disease	☐Cancer, radiation or chemotherapy
☐Blood disease or anemia	☐Gall bladder disease	-WOMEN ONLY-
☐Swollen ankles	☐Ulcer	☐Pregnant now
☐Shortness of breath or breathing problems	☐Intestinal problem	☐Presently in menopause ☐Passed menopause
☐Lung disease	☐Stroke	☐Had baby over 9 pounds
☐Asthma	☐Fainting or dizziness	☐Taking oral contraceptives
☐Diabetes	☐Epilepsy or seizures	-MEN ONLY-
☐Family history of diabetes	☐Depression, severe anxiety, or mental stress	☐Prostate problem

☐yes ☐no Have you had an allergic, unusual, or unpleasant reaction to any drug or medication?
Which drugs? _____
☐yes ☐no Do you now take or have you ever taken a drug (oral or injection) for bone loss (osteopenia, osteoporosis, Paget's disease, or with chemotherapy)?
☐yes ☐no Have you had any major illness, hospitalization or operation that was not mentioned above?
Please list. _____
☐yes ☐no Do you use tobacco? ☐Cigarettes, _____per day ☐Pipe or cigars ☐Oral tobacco
☐yes ☐no Do you take aspirin daily (regular or low-dose) or any other anticoagulant (blood thinner) medication?
☐yes ☐no Are you presently under the care of a physician for any reason? For what? _____

Name of your doctor: _____ Address: _____ Phone: _____

LIST ALL DRUGS YOU CURRENTLY TAKE	THE DOSAGE	THE REASON YOU TAKE IT.

I affirm that this information is accurate and true to the best of my knowledge. I understand that I must report changes in my health, medication, or dental status at the earliest possible time. I give permission to Dr. Wadhwa and/or Gandhi to use my diagnostic material, treatment information, X-rays, and photographs for research, educational presentation, and professional publication.

Signature _____ _____
(Parent must sign and list relationship if patient is a minor)