ASPEN leaf DENTAL
Cosmetic and family dentistry

Patient History

Patient Name_____

Each question must have an answer. Circle yes or no; or write in answers where appropriate.

A. General Information

Vital Signs (FOR OFFICE USE ONLY)

Date	WT	BP	HR
		/	
		/	
		/	
		/	
		/	

* Has there been any change in your general health in the past year?	Yes	No
* Have you had any serious illness or operations?	Yes	No
Have you been hospitalized within the past two (2) years?	Yes	No
Any recent unexplained gain or loss of weight?	Yes	No

* If under the care of a physician, give:

Name: _____

Address: _____

Phone Number: _____

B. Cardiovascular System

Do you or have you had:

High Blood Pressure?	Yes	No
Low Blood Pressure?	Yes	No
* Heart Attack?	Yes	No
* Heart Murmur(congenital heart disease)?	Yes	No
Heart Surgery (bypass, valve)?	Yes	No
Shortness of breath?	Yes	No
Chest Pain Upon Exertion (Angina)?	Yes	No
Swollen Ankles?	Yes	No
* Rheumatic Heart Disease or Fever?	Yes	No
* A Stroke?	Yes	No
A Pacemaker?	Yes	No

Other: _____

C. Nervous System

Do you or have you had:

Nervous breakdown/psychotherapy?	Yes	No
Epilepsy or Convulsions?	Yes	No
Neuritis, Neuralgia, or Numbness?	Yes	No
Fainting Spells or Seizures?	Yes	No

Other: _____

D. Respiratory System

Do you or have you had:

Any respiratory Disease?	Yes	No
Tuberculosis?	Yes	No
Sinus Trouble?	Yes	No
Hay Fever?	Yes	No
Pneumonia?	Yes	No
Asthma or Emphysema?	Yes	No
Chronic cough, sore throat, or coughing up blood?	Yes	No
Did you smoke?	Yes	No
Do you smoke?	Yes	No

E. Genitourinary System

Do you or have you had:

Kidney Disease?	Yes	No
Swollen Ankles?	Yes	No
Difficulty in or Frequent Urination?	Yes	No
Blood in your Urine?	Yes	No

Other: _____

F. Gastrointestinal System

Do you or have you had:

Stomach or Intestinal Trouble?	Yes	No
Indigestion, Diarrhea, Vomiting, or Constipation?	Yes	No
Appetite Problem?	Yes	No
* Hepititis or Jaundice?	Yes	No
Liver Disease?	Yes	No
Ulcers?	Yes	No

Other: _____

G. Endocrine System

Do you or have you had:

* Diabetes?	Yes	No
a. Do you frequently have to urinate?	Yes	No
b. Are you thirsty much of the time?	Yes	No
c. Is your mouth dry?	Yes	No
Thyroid Problem?	Yes	No
Parathyroid Problem?	Yes	No
Hormone Therapy?	Yes	No

Other: _____

H. Bones and Joints

Do you or have you had:

Arthritis?	Yes	No
Inflammatory Rheumatism?	Yes	No
* Joint Replacement?	Yes	No
Back or Neck Injury?	Yes	No

Other: _____

I. Blood - Lymphatic

Do you or have you had:

* Blood Disorder or Anemia?	Yes	No
* Abnormal Bleeding with Previous Extractions or Surgery?	Yes	No
* Transfusions?	Yes	No
Bruise Easily?	Yes	No
Swollen Lymph Nodes (glands)?	Yes	No

Other: _____

J. Infectious Disease

Do you or have you had:

* Hepatitis: Type A, B or other?	Yes	No
* AIDS, ARC, HIV, ANTI-HIV?	Yes	No
* Syphillis, Gonorrhea, Herpes?	Yes	No
Acute Pharyngitis (oral or strep)	Yes	No
Childhood Diseases: Chicken Pox, Rubella, Mumps, Rubeola?	Yes	No
* Are you or have you been an IV drug user?	Yes	No

Other:_____

K. Head, Eyes, Ears, Nose and Throat

Do you or have you had?

* Head or Jaw Injury?	Yes	No
Frequent Headaches?	Yes	No
Dizziness?	Yes	No
Vision Problems?	Yes	No
Hearing Problems?	Yes	No
Nose Bleeds?	Yes	No
Nasal Obstructions?	Yes	No
Chronic Sore Throat?	Yes	No
Halitosis?	Yes	No
Altered Taste Perceptions?	Yes	No
Dry Mouth?	Yes	No
Do you Wear Contact Lenses?	Yes	No

Other:_____

L. Medications

Are you taking any of the following?

* Antibiotics or Sulfa Drugs?	Yes	No
* Anticoagulants (blood thinners)?	Yes	No
* High Blood Pressure Medication?	Yes	No
* Cortisone (steroids)?	Yes	No
* Tranquilizers?	Yes	No
* Antihistimines?	Yes	No
* Aspirin?	Yes	No
* Insulin, Ornaise, or Similar Medication?	Yes	No
* Digitalis or other Heart Medication?	Yes	No
* Nitroglycerin?	Yes	No
* Chemotherapy?	Yes	No
* Chemically Dependent (drugs or alcohol)?	Yes	No
* Other Medications?	Yes	No

M. Allergies

Are you Allergic or had a Reaction to:

* Local Anesthetic (Novocaine, etc.)?	Yes	No
* Penicillin or other Antibiotics?	Yes	No
* Sulfa Drugs?	Yes	No
* Barbiturates, Sleeping pills?	Yes	No
* Aspirin?	Yes	No
* Iodine?	Yes	No
* Codeine or other Narcotics?	Yes	No
* Metals (rings, earrings, etc.)?	Yes	No
* Other Allergies?	Yes	No

N. Radiation History

Are you employed in any situation which exposes you to X-Rays or other ionizing radiation?	Yes	No
Have you had radiation therapy?	Yes	No

Other:_____

O. Dental History

(Denture patients go to Denture History)

Are you having dental pain or discomfort at this time?	Yes	No

Do you or have you had:

Frequent toothaches?	Yes	No
Periodontal (gum) disease?	Yes	No
Orthodontic Treatment?	Yes	No
Difficulty in Opening or Closing your Jaw?	Yes	No
Grinding or Clenching your Teeth?	Yes	No
Chronic Facial Pain?	Yes	No
Do you Brush Daily?	Yes	No
Do you Floss Daily?	Yes	No
Do you want to keep your Teeth?	Yes	No
Does having Dental Treatment make you nervous?	Yes	No
Have you had a bad experience in a dental office?	Yes	No

Have your Dental Experiences in General been?
(please circle one)

GOOD AVERAGE POOR

Children Only:

a. Flouride (dietary Hx)?	Yes	No
b. Good Oral Habits?	Yes	No
c. Birth History Normal?	Yes	No

Denture History:

a. Do you think you need dentures?	Yes	No
b. How long have you worn Dentures? _____		
c. How old are your present Dentures? _____		

P. Women Only

* Are you Pregnant?	Yes	No

Do you or have you had:

Menstrual Problems?	Yes	No
Breast Cancer/Tumor?	Yes	No
* Are you taking Birth Control Pills?	Yes	No
Have you been through Menopause?	Yes	No

Other: _____

Please list current medications:

To the best of my Knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health o if my medications change, I will inform Aspen Leaf Dental personnel at the time of my next appointment, without fail.

_____ _____ _____ _____

Date Dentist Signature Witness Signature Patient, Parent or Guardian Signature

Medical History/Physical Evaluation Update:

Date:	Changes: Yes / No	Date:	Changes: Yes / No	Date:	Changes: Yes / No
_____		_____		_____	

_____	Yes / No	_____	Yes / No	_____	Yes / No
_____	Yes / No	_____	Yes / No	_____	Yes / No