bonney lake dental center
delia constantin dds

PATIENT INFORMATION

Patient Name: ______________________________ Date: ______________

Dental Health History

	Y	N
Name of previous dentist: ______________________		
Date of last dental visit: ______________________		
Are you currently in pain?	☐	☐
Do you have a specific dental problem? Please explain: ______________________	☐	☐
Are you fearful of dental treatment? Scale of 1 (not at all) to 10 (very): ______	☐	☐
Your current health status is: ☐ good ☐ fair ☐ poor		
Have you had problems with previous dental treatment?	☐	☐
Have you had trouble getting numb or reactions to local anesthetic?	☐	☐
Do your require antibiotics before dental treatment?	☐	☐
Do you ever have clicking, popping or discomfort in your jaw joint (TMJ/TMD)?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do your gums bleed easily?	☐	☐
Do you gag easily?	☐	☐
Have you noticed any slow-healing sores in your mouth?	☐	☐
Are your teeth sensitive to hot, cold, sweets, or biting?	☐	☐
Do you have a dry mouth?	☐	☐
Have you ever whitened your teeth?	☐	☐
Do you have mobility in any of your teeth?	☐	☐
Do you still have your wisdom teeth?	☐	☐
Have you had any cavities in the past 3 years?	☐	☐
Do you prefer to save your teeth?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐

I understand that the information I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform the office of any changes in my medical status.

Patient Signature:	Date:

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MEDICAL HISTORY

Patient Name: ______________________________ Date: ______________
Physician's name & phone number: ______________________________
Date/Reason of last visit to physician: ______________________________
Do you have, or have you had, any of the conditions listed below:

	Y	N
Heart problems	☐	☐
Angina/Chest pain	☐	☐
Shortness of breath	☐	☐
High/Low blood pressure	☐	☐
Heart murmur	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Heart Attack	☐	☐
Artificial prosthesis (heart valve)	☐	☐
Anemia or other blood disorder	☐	☐
Abnormal/prolonged bleeding	☐	☐
Blood transfusion	☐	☐
Asthma	☐	☐
Sinus problems	☐	☐
Tuberculosis/Other respiratory disease	☐	☐
Kidney disease	☐	☐
Liver disease/Jaundice	☐	☐
Hepatitis Type _____	☐	☐
Gastrointestinal problems/ulcers/reflux	☐	☐
Stroke	☐	☐
Depression	☐	☐

	Y	N
Frequent or severe headaches	☐	☐
Diabetes	☐	☐
Thyroid problems	☐	☐
Arthritis	☐	☐
Autoimmune disorder	☐	☐
Joint replacement (total hip, pins, implants)	☐	☐
Persistent cough or swollen glands	☐	☐
Premedication required by physician	☐	☐
Cancer/Tumor (surgery/radiation/chemo)	☐	☐
HIV -positive/AIDS/STD	☐	☐
Epilepsy/Seizures/Other neurologic disease	☐	☐
Head or neck injuries	☐	☐
Glaucoma	☐	☐
Contact lenses	☐	☐
Alcohol How many drinks per week? _______	☐	☐
Smoking How much per day? __________	☐	☐
Do you chew tobacco?	☐	☐
History of alcohol or drug abuse	☐	☐
Take medication for weight management (fen-phen)	☐	☐
Osteoporosis – taking Bisphosphonates (Fosamax, Boniva, Actonel, Aridia, Zometa)	☐	☐

Are you allergic to?

Aspirin, ibuprofen, acetaminophen	☐	☐
Penicillin or other antibiotics	☐	☐
Codeine, Demerol or other narcotics	☐	☐
Latex	☐	☐
Local anesthetic (Novocaine)	☐	☐
Sulfa drugs	☐	☐
Metals	☐	☐
Fluoride	☐	☐
Acrylic	☐	☐
Other ______________________	☐	☐

Women:

Are you pregnant? Due date: _________	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

List any medications taken within the last 2 years:
Drug: Purpose:

Do you have any other condition not listed above?
Please describe: ______________________________

Patient Signature:	Date:
Doctor Signature:	Date: