CR DENTAL GROUP

MEDICAL HISTORY

Patient Name_____ Nickname_____ Age _____

Name of Physician_____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury	❑	❑
2. allergic reaction to		
❑ aspirin, ibuprofen, acetomenophen		
❑ penicillin		
❑ erythromycin		
❑ tetracycline		
❑ codeine		
❑ local anesthetic		
❑ fluoride		
❑ metals (gold, stainless steel)		
❑ latex		
❑ any other medications _____		
3. heart problems	❑	❑
4. heart murmur	❑	❑
5. rheumatic fever	❑	❑
6. scarlet fever	❑	❑
7. high blood pressure	❑	❑
8. low blood pressure	❑	❑
9. a stroke	❑	❑
10. artificial prosthesis (i.e. heart valve or joints)	❑	❑
11. anemia or other blood disorder	❑	❑
12. prolonged bleeding due to a slight cut	❑	❑
13. emphysema	❑	❑
14. tuberculosis	❑	❑
15. asthma	❑	❑
16. sinus problems	❑	❑
17. kidney disease	❑	❑
18. liver disease	❑	❑
19. jaundice	❑	❑
20. thyroid or parathyroid disease	❑	❑
21. hormone deficiency	❑	❑
22. high cholesterol	❑	❑
23. diabetes	❑	❑
24. stomach or duodenal ulcer	❑	❑
25. digestive disorders	❑	❑

	YES	NO
26. arthritis	❑	❑
27. glaucoma	❑	❑
28. contact lenses	❑	❑
29. head or neck injuries	❑	❑
30. epilepsy, convulsions (seizures)	❑	❑
31. viral infections and cold sores	❑	❑
32. any lumps or swelling in the mouth	❑	❑
33. hives, skin rash, hay fever	❑	❑
34. venereal disease	❑	❑
35. hepatitis (type _____)	❑	❑
36. HIV / AIDS	❑	❑
37. tumor, abnormal growth	❑	❑
38. radiation therapy	❑	❑
39. chemotherapy	❑	❑
40. emotional problems	❑	❑
41. psychiatric treatment	❑	❑
42. antidepressant medication	❑	❑
43. alcohol / drug dependency	❑	❑
ARE YOU:		
44. presently being treated for any illness	❑	❑
45. aware of a change in your general health	❑	❑
46. often exhausted or fatigued	❑	❑
47. subject to frequent headaches	❑	❑
48. a heavy smoker (1 pack or more a day)	❑	❑
49. considered a touchy person	❑	❑
50. often unhappy or depressed	❑	❑
51. easily upset or irritated	❑	❑
52. FEMALE - taking birth control pills	❑	❑
53. FEMALE - pregnant	❑	❑
54. MALE - Prostate disorders	❑	❑

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment _____

_____

List any medications, herbal supplements, and or vitamins taken within the last two years_____

_____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature_____ Date_____

Doctor's Remarks: _____

_____ Doctor's Signature_____

OVER

7777 Forest Lane, Suite C-104, Dallas, TX 75230 972/566-4990

CR DENTAL GROUP

DENTAL HISTORY

Referred by _____

Previous dentist _____ How long _____

Most recent dental exam _____ Most Recent dental x-ray _____

Most recent dental treatment _____

How often do you have your teeth cleaned? 3 mo._____ 4 mo._____ 6 mo._____ 1 year or longer_____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

1. unhappy with the appearance of your teeth ..... ❑ ❑
2. unfavorable dental experiences ..... ❑ ❑
3. dental fears ..... ❑ ❑
4. problems with effectiveness or bad reactions to dental anesthetic ..... ❑ ❑
5. orthodontic treatment (braces) when ..... ❑ ❑
6. periodontal (gum) treatment when ..... ❑ ❑
7. bleeding gums ..... ❑ ❑
8. avoid brushing any part of your mouth ..... ❑ ❑
9. part of your mouth is sensitive to temperature ..... ❑ ❑
10. sore teeth ..... ❑ ❑
11. a burning sensation in your mouth ..... ❑ ❑
12. difficulty swallowing ..... ❑ ❑
13. an unpleasant taste or odor in your mouth ..... ❑ ❑
14. dry mouth, throat, and or eyes ..... ❑ ❑
15. jaw problems (temporomandibular joint) ..... ❑ ❑
16. difficultly opening your mouth widely ..... ❑ ❑
17. stiff neck muscles ..... ❑ ❑
18. awaken with an awareness of your teeth or jaws ..... ❑ ❑
19. tension headaches ..... ❑ ❑
20. clench or grind your teeth ..... ❑ ❑
21. jaw clicking or popping ..... ❑ ❑
22. lost any teeth ..... ❑ ❑
23. do you sweat or tremble a lot during examination ..... ❑ ❑
24. do strange people or places make you afraid ..... ❑ ❑

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES NO (Please check Yes or No)

❑ ❑ Has your present denture been relined? When _____

❑ ❑ Is your present denture a problem? Describe _____

❑ ❑ Satisfied with the appearance? _____

❑ ❑ Satisfied with the comfort? _____

❑ ❑ Satisfied with the chewing ability? _____

When did you receive your first partial or complete denture?_____

How long have you worn your present denture?_____

Patient's Signature_____ Date_____

Doctor's Remarks: _____

_____ Doctor's Signature_____

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