Health History DIXON ORTHODONTIC DENTAL GROUP

Primary reason for this dental appointment: (Circle) Examination Emergency Consultation Circle Appropriate Answer (Cave blank if you do not understand question): 1. Yes No 1. Yes No 1. Sy our general health good? 2. Yes No 1. Has there been a change in your health within the last year? 3. Yes No 1. Has there been a change in your health within the last year? 3. Yes No 1. Are you being treated by a physician now? Why? Date of last Dental Exam: 5. Yes No Are you allergize to any medications, or its your general may medications, or its or drugs? Please circle Are you having any medications or substances? Please list: 6. Yes No Are you allergize to any medications, or its or drugs? Please circle Are you have a specific dental problem? Describe 9. Yes No Do you have dental examinations on a routine basis? Last visit? 9. Yes No Do you have dental examinations on a routine basis? 11. Yes No Do you have dental examinations on a routine basis? 12. Yes No Do you brush and floss on a routine basis? 13. Yes No Do you they our smite? 14. Yes No Do you put we exit bed? Describe 13. Yes No Do you were have circled; popping, or discomfort in the jaw joint? Do you brusx or grind? Approximate due of last full mouth x-rays (16 or more films) 13. Yes No Do you were have circled; popping, or discomfort in the jaw joint? Do you brusx or grind? Approximate due of last full mouth x-rays (16 or more films) 14. Yes No Do you ever have circled; popping, or discomfort in the jaw joint? Do you brusx or grind? 15. Yes No Do you ever have circled; popping, or discomfort in the jaw joint? Do you brusx or grind? 14. Yes No Do you ever have circled; popping, or discomfort in the jaw joint? Do you brusx or grind? 15. Yes No Do you ever have circled; popping, or discomfort in the jaw joint? Do you brusx or grind? 16. Addacy problems 17. Yes No Do you ever have circled; popping, or discomfort in the jaw joint? Do you brusx or grind? 17. Hart touble?/Discas 18. Yes No Do you alware or a deal of last full mouth x-rays (16 or more films) 19. Hart tou	Patient Name:	Birth Date:	Date:	
1. Yes No Is your general health good? 2. Yes No Has there been a change in your health within the last year? 3. Yes No Has there been a change in your health within the last year? 3. Yes No Are you being treated by a physician now? Why? Date of last medical exam:				Consultation
2. Yes No Has there been a change in your health within the last year? 3. Yes No Have you been hospitalized or had a serious illness in the last three years? 1 Y Yes No Are you being treated by a physician now? Why ? Date of last medical exam.		ou do not understand que	stion):	
3. Yes No Have you been hospitalized or had a serious illness in the last three years? If YES, Why? Are you being treated by a physician now? Why?				
If YES, why?			2	
5. Yes No Are you taking any medications of substances? Please its:	If VFS why?			
5. Yes No Are you taking any medications of substances? Please its:	4. Yes No Are you being treated by a physician r	10w? Why ?		
5. Yes No Are you taking any medications of substances? Please its:	Date of last medical exam:	Date of las	t Dental Exam:	
6. Yes No Are you allergic to any medications, pills, or drugs? Please circle: Asprint Penicillin Codeine Acrylic Metal Latex Rubber Other Please circle: Penical History 7. Yes No Do you in pain now? 8. Yes No Do you have a specific dental problem? Describe 9. Yes No Do you have dental examinations on a routine basis? Last visit?	5. Yes No Are you taking any medications or sul	ostances? Please list:		
Dental History 7. Yes No Are you in pain now? 8. Yes No Do you have dental examinations on a routine basis? Last visit? 10. Yes No Do you brush and floss on a routine basis? 11. Yes No Do you brush and floss on a routine basis? 12. Yes No Do you brush and floss on a routine basis? 13. Yes No Do you guins ever bleed? Describe 13. Yes No Do you brush and floss on a routine basis? 14. Yes No Do you brus ever hale? 15. Yes No Do you er have clicking, popping, or discomfort in the jaw joint? Do you brux or grind? Approximate date of last full mouth x-rays (16 or more films)	6. Yes No Are you allergic to any medications, p	oills, or drugs?		
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8. Yes No Do you have a specific dental problem? Describe	Dental History			
9. Yes No Do you have dental examinations on a routine basis? Last visit?	7. Yes No Are you in pain now?			
9. Yes No Do you have dental examinations on a routine basis? Last visit?	8. Yes No Do you have a specific dental problem	n? Describe		
10. Yes No Do you think you have active decay or gum disease? 11. Yes No Do your gums ever bleed? Describe	9. Yes No Do you have dental examinations on a	routine basis? Last visit?		
11. Yes No Do your guns ever bleed? Describe	10. Yes No Do you think you have active decay o	r gum disease?		
12. Yes No Do your gums ever bled? Describe				
13. Yes No Do you like your smile? 14. Yes No Does food catch between your teeth? Any loose teeth? 15. Yes No Do you ver have clicking, popping, or discomfort in the jaw joint? Do you brux or grind? Approximate date of last full mouth x-rays (16 or more films)				
14. Yes No Does food catch between your teeth? Any loose teeth? 15. Yes No Do you ever have clicking, popping, or discomfort in the jaw joint? Do you burx or grind? Approximate date of last full mouth x-rays (16 or more films)Bitewing (4 films)	, , , , _			
15. Yes No Do you ever have clicking, popping, or discomfort in the jaw joint? Do you brux or grind?		Any loose teeth?		
Approximate date of last full mouth x-rays (16 or more films)			Do you brux or grind?	
Medical History Do you have or have you had any of the following? Please check appropriate boxes. If yes to * questions, call prior to your appointment to your appointent there the your pass appointent to your appoi				4 films)
Do you have or have you had any of the following? Please check appropriate boxes. If yes to * questions, call prior to your appointment Yes No Yes No Yes No 16 Heart trouble / Disease 35 Bloody stools 54 Cancer 74 Renal dialysis 17 Heart trouble / Disease 36 Bruise easily 55 Cancer 74 Renal dialysis 18 Hart track / Failure 38 Excessive bleeding 57 Chemotherapy 76 Hart trip rotol Disease 19 Heart attack / Failure 38 Excessive bleeding 57 Chemotherapy 76 Hart rificial heart disorder 79 Hort disease 78 Heart murmur* 74 Heart murmur* 40 Hemophilia 59 HUlcers 78 Heart numur* 74 Heart murmur* 40 Heart numur* 40 Hart nup disease 40			Dite wing (
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To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail. X Date Date Date Patient Signature (parent or guardian) Reviewed by Doctor Date Date BP History review and significant findings Medical Updates Date Patient's signature Reviewed by Output for the dentist and staff at the next appointment without fail.	16. Heart trouble / Disease 35. Bloody signation 17. Irregular heart beat 36. Bruise ea 18. Angina / Chest pain 37. Anemia 19. Heart attack / Failure 38. Excessive 20. Congenital heart disorder 39. Sickle ce 21. Heart murmur * 40. Hemophi 22. Mitral valve prolapse * 41. Leukemia 23. Rheumatic fever * 42. Blood tra 24. Artificial heart valve * 43. Swelling 25. Heart pace maker * 44. Lung disc 26. Artificial joint * 45. Breathing 27. Heart surgery 46. Shortness 28. High blood pressure 47. Frequent 29. Low blood pressure 48. Hay feve 31. Stroke 50. Asthma 32. Scarlet Fever 51. Emphyse 33. Unexplained fever 52. Allergies 34. Have you ever had any other	tools54.Tusily55.Casily55.Ca56.Rableeding57.ClIl disease58.Stlia59.Ula60.Ransfusion61.Frof limbs62.Diproblems64.Hicough66.Hasof breath65.Licough66.Hana70.Ya(Medicines)71.P(Pollen / Dust)72.DiIlness not checked above?Disately about any problem?l office always been positive?	ancer 74 adiation therapy 75 nemotherapy 76 omach disease 77 cers 78 cycent weight loss 79 equent diarrhea 80 abetes 81 accessive thirst 82 ypoglycemia 82 epatitis A 85 epatitis B or C 86 ght sweats 87 y mouth 88 ellow jaundice 88 sychiatric care 90 rug addiction 91	3. Kidney problems 4. Renal dialysis 5. Thyroid Disease 6. Arthritis / Gout 7. Rheumatism 8. Pain in jaw joint 9. Venereal disease 0. AIDS / HIV+ 1. Genital herpes 2. Glaucoma 3. Contact lenses 4. Cold sores 5. Fever blisters 6. Herpes 7. Convulsions 8. Epilepsy or seizure 9. Fainting or dizzines: 0. Alzheimer's disease 1. Tumors or growths
To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail. X Date Date Patient Signature (parent or guardian) Reviewed by Doctor Date Date History review and significant findings Medical Updates Date Patient's signature Reviewed by			Taking oral contra	ceptives
Reviewed by Doctor Date BP History review and significant findings	To the best of my knowledge, all the preceding answers are correct. If I have any char	ges in my health status or if my medicines cha	-	-
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History review and significant findings Medical Updates Date Exceptions Patient's signature Reviewed byNone	Reviewed by Doctor	Date	B	Р
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None None