Carolina Aesthetic Dentistry

Dental History

Please take a few minutes to fill out this form as completely and as accurately as possible. If you have any questions, our staff is available to assist you.

Name _____

Last *First* *Middle* *Title (Dr., Mr., Mrs., Sr., Jr., etc.)* *Name You Wish to be Called*

Date of Birth_____ Today's Date _____ Reason for Today's Visit _____

Date of Last Dental Visit _____ Date of Last Dental X-rays_____

Former Dentist _____Address _____City/State _____

Please check any item below which you have been experiencing:

❑ Bad Breath	❑ Sores/Growths in Your Mouth	❑ Food Collecting between Teeth	❑ Sensitive to Cold
❑ Loose Teeth	❑ Grinding Teeth	❑ Problems when Chewing	❑ Other_____
❑ Broken Fillings	❑ Clicking or Popping Jaw	❑ Sensitive to Sweets	❑ Other_____
❑ Dry Mouth	❑ Bleeding Gums	❑ Sensitive to Hot	

How often do you floss? _____How often do you brush? _____

Do you smoke or use tobacco products? ❑ Yes ❑ No If yes, how much per day? _____

Have you had any serious trouble associated with any past dental treatment? ❑ Yes ❑ No If yes, please explain _____

_____

Medical History

Physician's Name_____ Date of Last Visit _____

Physician's Address _____City _____ State _____Zip Code _____

Are you presently under the care of a physician? ❑ Yes ❑ No If yes, please explain _____

Have you had any serious illness or operations? ❑ Yes ❑ No If yes, please explain _____

Have you been hospitalized within the past 5 years? ❑ Yes ❑ No If yes, please explain _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, please explain _____

Have you ever had surgery, radiation, or chemotherapy for a tumor, cancer, or other condition? ❑ Yes ❑ No

If yes, please explain _____

Women please check the following if you are: ❑ Pregnant ❑ Nursing ❑ Taking Birth Control

Please check if you currently have or have had any of the following:

❑ AIDS/HIV	❑ Chest Pains	❑ **Heart Murmur**	❑ Liver Disease	❑ Stroke
❑ Alcoholism	❑ Circulatory Problems	❑ Heart Problems	❑ **Mitral Valve Prolapse**	❑ Swelling of Feet/Ankles
❑ Anemia	❑ Coughing up Blood	❑ Hemophilia	❑ Pacemaker	❑ Thyroid Problems
❑ Arthritis	❑ Diabetes	❑ Hepatitis - Type A	❑ Persistent Cough	❑ Tonsillitis
❑ **Artificial Heart Valve**	❑ Epilepsy	❑ Hepatitis - Type B	❑ Radiation Therapy	❑ Tuberculosis
❑ **Artificial Joints**	❑ Fainting	❑ Hepatitis - Type C	❑ Respiratory Disease	❑ Ulcer
❑ Asthma	❑ Glaucoma	❑ High Blood Pressure	❑ **Rheumatic Fever**	❑ Venereal Disease
❑ Back Problems	❑ Headaches	❑ Hives	❑ Scarlet Fever	❑ Other_____
❑ Blood Clots	❑ Heart Abnomalities	❑ Pain in the Jaw	❑ Shortness of Breath	❑ Other_____
❑ Cancer	❑ Heart Attack	❑ Kidney Disease	❑ Skin Rash	❑ Other_____

Are you presently taking any medications? ❑ Yes ❑ No If yes, please list all medications you are currently taking. _____

_____

Are you presently taking any herbal medications? ❑ Yes ❑ No If yes, please list all medications you are currently taking. _____

_____

Please check if you are allergic to the medication or item listed:

❑ Aspirin	❑ Ibprofen	❑ Local Anesthetic	❑ Sulfa
❑ Barbiturates (Sleeping Pills)	❑ Iodine	❑ Metals	❑ Other_____
❑ Codeine	❑ Latex	❑ Penicillin	❑ Other_____

Do you have any additional concerns we should be aware of? ❑ Yes ❑ No If yes, please explain _____

_____

To the best of my knowledge, the above information is accurate and complete. I understand it isi my responsibility to let the office know if I, or my minor child, have a change in health.

Signature of Patient, Parent or Guardian _____ Today's Date _____