VIDYA COLOSPATE, D.M.D., PLLC

**PLEASE COMPLETE ALL INFORMATION – THANK YOU**

**PATIENT LAST NAME:** _____ **PATIENT FIRST NAME:** _____

## DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

| Please check if you have/had: | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Bad breath | ❑ | ❑ | Head, neck, jaw pain, or aches | ❑ | ❑ |
| Blisters on lips or mouth | ❑ | ❑ | Lip or cheek biting | ❑ | ❑ |
| Burning sensation on tongue | ❑ | ❑ | Loose teeth or broken fillings | ❑ | ❑ |
| Chew on one side of mouth | ❑ | ❑ | Mouth breathing | ❑ | ❑ |
| Cigarette, pipe, or cigar smoking | ❑ | ❑ | Orthodontic treatment | ❑ | ❑ |
| Smokeless tobacco | ❑ | ❑ | Nitrous Oxide | ❑ | ❑ |
| Dry mouth | ❑ | ❑ | Periodontal treatment | ❑ | ❑ |
| Food collection between teeth | ❑ | ❑ | Sensitivity to pressure or irritants | ❑ | ❑ |
| Clench or grind teeth | ❑ | ❑ | (cold, heat, sweets) | | |
| Growths or sore spots in your mouth | ❑ | ❑ | How often do you floss? _____ | | |
| Gums swollen, tender or bleeding | ❑ | ❑ | How often do you brush? _____ | | |

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ❑Yes ❑No

If Yes, please explain _____

Have you ever had trouble from previous dental care? ❑Yes ❑No If Yes, please explain _____

## MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____ Blood Pressure _____

Have you had any serious illnesses or operations Yes ❑ No ❑ If yes, please describe _____

Have you ever had a blood transfusion Yes ❑ No ❑ If yes, give approximate dates _____

(Women) Are you pregnant? Yes ❑ No ❑ Due date _____ Nursing? Yes ❑ No ❑ Taking birth control pills? Yes ❑ No ❑

| Please check if you have/had: | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Allergies, hay fever, sinusitis | ❑ | ❑ | Headaches | ❑ | ❑ | Slow healing wounds | ❑ | ❑ |
| Anemia | ❑ | ❑ | Heart murmur | ❑ | ❑ | Stroke | ❑ | ❑ |
| Arthritis, Rheumatism | ❑ | ❑ | Heart problems | ❑ | ❑ | Swelling of feet or ankles | ❑ | ❑ |
| Artificial heart valves | ❑ | ❑ | Hepatitis type _____ | ❑ | ❑ | Thyroid problems | ❑ | ❑ |
| Artificial joints | ❑ | ❑ | Herpes | ❑ | ❑ | Tonsilitis | ❑ | ❑ |
| Asthma | ❑ | ❑ | High blood pressure | ❑ | ❑ | Tuberculosis | ❑ | ❑ |
| Required Hospitalization | ❑ | ❑ | Any immune deficiency | ❑ | ❑ | Tumor or growth on head/neck | ❑ | ❑ |
| Have you used steroids | ❑ | ❑ | Jaundice | ❑ | ❑ | Ulcer | ❑ | ❑ |
| Date of last episode _____ | ❑ | ❑ | Kidney disease | ❑ | ❑ | Venereal disease | ❑ | ❑ |
| Bleeding abnormally with operations or surgery | ❑ | ❑ | Low blood pressure | ❑ | ❑ | Weight loss, unexplained | ❑ | ❑ |
| Blood disease, clotting disorders | ❑ | ❑ | Mitral valve prolapse | ❑ | ❑ | Do you wear contact lenses? | ❑ | ❑ |
| Cancer | ❑ | ❑ | Osteoporosis | ❑ | ❑ | Do you consume alcoholic beverages? | ❑ | ❑ |
| Chemical dependency | ❑ | ❑ | Osteopenia | ❑ | ❑ | Are you currently under the care of a Physician? | ❑ | ❑ |
| Chemotherapy | ❑ | ❑ | Pacemaker | ❑ | ❑ | Are you allergic/sensitive to Latex? | ❑ | ❑ |
| Circulatory problems | ❑ | ❑ | Radiation treatments | ❑ | ❑ | Allergic to Penicillin, Aspirin, or other drugs? | ❑ | ❑ |
| Cortisone treatments | ❑ | ❑ | Respiratory disease | ❑ | ❑ | *If Yes, please specify* _____ | | |
| Cough, persistent or bloody | ❑ | ❑ | Rheumatic fever | ❑ | ❑ | | | |
| Diabetes | ❑ | ❑ | Scarlet fever | ❑ | ❑ | | | |
| Emphysema | ❑ | ❑ | Shortness of breath | ❑ | ❑ | List any medications that you are taking: | | |
| Epilepsy | ❑ | ❑ | Sinus trouble | ❑ | ❑ | | | |
| Fainting | ❑ | ❑ | Sickle cell anemia | ❑ | ❑ | | | |
| Glaucoma | ❑ | ❑ | Skin rash | ❑ | ❑ | | | |

## AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Reviewed by: _____ Date _____

# DENTAL & MEDICAL HEALTH HISTORY