Dental Wellness
of Westlake Village

Patient Name _____ **Birth Date** ____ / ____ / _____ **Date** ____ / ____ / _____

DENTAL HISTORY

What is the reason for today's visit? _____

When was your last dental visit? _____

Y ◯ N ◯ Do you require antibiotics before dental treatment?
Y ◯ N ◯ Do your gums bleed?
Y ◯ N ◯ Are your teeth sensitive to cold, heat or tooth brushing?
Y ◯ N ◯ Do you have, or have you ever had, pain in your jaw joint (TMJ)?
Y ◯ N ◯ Do you clench your jaw or grind your teeth?
Y ◯ N ◯ Do you experience extreme anxiety prior to or during dental treatments?
Y ◯ N ◯ Is there anything you would like to change about the appearance of your smile?

If yes, please explain: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in around your mouth, your mouth is a part of your entire body. Health problems you may have, or medication that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name _____ Physician's Phone _____

Y ◯ N ◯ **Are you under a physician's care now?**
If yes, please explain: _____

Y ◯ N ◯ **Have you ever been hospitalize or had a major operation?**
If yes, please explain: _____

Y ◯ N ◯ **Have you ever had a serious head or neck injury?**
If yes, please explain: _____

Y ◯ N ◯ **Are you taking any medications, pills or drugs?**
If yes, please explain: _____

Y ◯ N ◯ **Do you use controlled substances?**
If yes, please explain: _____

Y ◯ N ◯ **Do you take, or have you taken, Phen-Fen or Redux?**
If yes, please explain: _____

Y ◯ N ◯ **Have you ever take Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?**
If yes, please explain: _____

Y ◯ N ◯ **Are you on special diet?**

Y ◯ N ◯ **Do you use tobacco ?**

Allergies

Acrylic	Y ◯	N ◯	Metal	Y ◯	N ◯
Aspirin	Y ◯	N ◯	Penicillin	Y ◯	N ◯
Codeine	Y ◯	N ◯	Sulfa drugs	Y ◯	N ◯
Local Anesthetics	Y ◯	N ◯	Other?	Y ◯	N ◯
Latex	Y ◯	N ◯			

Female Patients

Are you pregnant? If yes , # of weeks: _____	Y ◯	N ◯
Are you nursing?	Y ◯	N ◯
Are you taking Birth Control Pills?	Y ◯	N ◯

Do you have, or have you had, any of the following medical conditions?

AIDS/HIV positive	Y ◯	N ◯	Excessive Thirst	Y ◯	N ◯	Mitral Valve Prolapse	Y ◯	N ◯
Alzheimer's disease	Y ◯	N ◯	Fainting Spells/Dizziness	Y ◯	N ◯	Osteoporosis	Y ◯	N ◯
Anaphylaxis	Y ◯	N ◯	Frequent Cough	Y ◯	N ◯	Pain in Jaw Joints	Y ◯	N ◯
Anemia	Y ◯	N ◯	Frequent Diarrhea	Y ◯	N ◯	Parathyroid Disease	Y ◯	N ◯
Angina	Y ◯	N ◯	Frequent Headaches	Y ◯	N ◯	Psychiatric Care	Y ◯	N ◯
Arthritis/Gout	Y ◯	N ◯	Genital Herpes	Y ◯	N ◯	Radiation Treatments	Y ◯	N ◯
Artificial Heart Valve	Y ◯	N ◯	Glaucoma	Y ◯	N ◯	Recent Weight Loss	Y ◯	N ◯
Artificial Joint	Y ◯	N ◯	Hay fever	Y ◯	N ◯	Renal Dialysis	Y ◯	N ◯
Asthma	Y ◯	N ◯	Heart Attack / Failure	Y ◯	N ◯	Rheumatic Fever	Y ◯	N ◯
Blood Disease	Y ◯	N ◯	Heart Murmur	Y ◯	N ◯	Rheumatism	Y ◯	N ◯
Blood Transfusion	Y ◯	N ◯	Heart Pacemaker	Y ◯	N ◯	Scarlet Fever	Y ◯	N ◯
Breathing problems	Y ◯	N ◯	Heart Trouble/ Disease	Y ◯	N ◯	Shingles	Y ◯	N ◯
Bruise easily	Y ◯	N ◯	Hemophilia	Y ◯	N ◯	Sickle Cell Disease	Y ◯	N ◯
Cancer	Y ◯	N ◯	Hepatitis A	Y ◯	N ◯	Sinus Trouble	Y ◯	N ◯
Chemotherapy	Y ◯	N ◯	Hepatitis B or C	Y ◯	N ◯	Spina Bifida	Y ◯	N ◯
Chest pains	Y ◯	N ◯	Herpes	Y ◯	N ◯	Stomach/Intestinal Disease	Y ◯	N ◯
Cold sores/Fever blisters	Y ◯	N ◯	High Blood Pressure	Y ◯	N ◯	Stroke	Y ◯	N ◯
Congenital Heart Disorder	Y ◯	N ◯	High Cholesterol	Y ◯	N ◯	Swelling of Limbs	Y ◯	N ◯
Convulsions	Y ◯	N ◯	Hives or Rash	Y ◯	N ◯	Thyroid Disease	Y ◯	N ◯
Cortisone medicine	Y ◯	N ◯	Hypoglycemia	Y ◯	N ◯	Tonsillitis	Y ◯	N ◯
Diabetes	Y ◯	N ◯	Irregular Heartbeat	Y ◯	N ◯	Tuberculosis	Y ◯	N ◯
Drug Addiction	Y ◯	N ◯	Kidney Problems	Y ◯	N ◯	Tumors or Growths	Y ◯	N ◯
Easily winded	Y ◯	N ◯	Leukemia	Y ◯	N ◯	Ulcers	Y ◯	N ◯
Emphysema	Y ◯	N ◯	Liver Disease	Y ◯	N ◯	Venereal Disease	Y ◯	N ◯
Epilepsy or Seizures	Y ◯	N ◯	Low Blood Pressure	Y ◯	N ◯	Yellow Jaundice	Y ◯	N ◯
Excessive Bleeding	Y ◯	N ◯	Lung Disease	Y ◯	N ◯			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Parent/Guardian _____ **Date** _____ / _____ / _____

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