PFLUGERVILLE SMILES DENTISTRY
Creating Miles of Smile. Your Smile is Our Passion.

General Health Information

Date:_____
Patient Name: _____ **BIRTHDATE:**_____**AGE:**_____
First Last

DENTAL HISTORY

1. Reason for Visit/Main Concern: Check-Up Cleaning Toothache Other
_____
2. Are there other conditions we should be aware off? YES NO If, Yes, please specify
_____
3. When was your last visit to a dentist?_____4. What treatment was performed?_____
5. Was the treatment planning complete?_____6. When were the last time dental x-rays taken_____
7. Were teeth cleaned? YES NO 8. Have you had gum disease treatment? YES NO
9. Have you ever had prolonged bleeding after an extraction? YES NO
If, Yes, please specify _____
10. Have you had any problems with previous dental treatment? YES NO
If, Yes, please specify _____
10. Do you grind your teeth, clinch your jaws, or have symptoms of grinding like clicking, popping, pain or locking? YES NO
If, Yes, please specify _____
10. Have you ever been diagnosed or treated for TMD or TMJ (Temporomandibular Joint Dysfunction)? YES NO
If, Yes, please specify _____
10. Do your gums bleed easily? YES NO 14. Do you feel you have bad breath? YES NO
15. Are your teeth sensitive to hot or cold? YES NO 16. Would you like your teeth whiter? YES NO
17. Are you happy with you existing smile? YES NO If, Yes, please specify _____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES NO If, Yes, please specify _____
Dr. Name: _____ **Contact #:** _____
2 Are you allergic to penicillin, codeine, local anesthetics, tranquillizer and or any other drugs or medicine? YES NO
If, Yes, please specify_____
2 Are you taking any medications at this time, including birth control? YES NO
If, Yes, please specify_____
2 For women only: Are you pregnant now? YES NO If, Yes, please specify _____
3 Are there any other health problems of which we should be aware of? Please specify _____
4 Are you diagnosed with any of the below conditions or medical conditions?

Please check YES/NO appropriately

Artificial Heart Valve	YES	NO	_____	Hepatitis	YES	NO	_____
AIDS/HIV+	YES	NO	_____	High Blood Pressure	YES	NO	_____
Anemia	YES	NO	_____	Jaundice	YES	NO	_____
Angia	YES	NO	_____	Joint Replacement	YES	NO	_____
Arthritis	YES	NO	_____	Kidney Disease	YES	NO	_____
Asthma	YES	NO	_____	Latex Allergy	YES	NO	_____
Bisphosphonate Therapy	YES	NO	_____	Liver Problems	YES	NO	_____
Bleeding Problems	YES	NO	_____	Low Blood Pressure	YES	NO	_____
Cancer	YES	NO	_____	Lung Disease	YES	NO	_____
Chemo/Radiation Therapy	YES	NO	_____	Pacemaker	YES	NO	_____
Cosmetic Surgery	YES	NO	_____	Psychiatric Care	YES	NO	_____
Diabetes	YES	NO	_____	Rheumatic Fever	YES	NO	_____
Dizzy Spells	YES	NO	_____	Sinus	YES	NO	_____
Drug Addiction	YES	NO	_____	Sleep Apnea	YES	NO	_____
Emphysema	YES	NO	_____	Tobacco	YES	NO	_____
Epilepsy	YES	NO	_____	Stroke	YES	NO	_____
Fainting	YES	NO	_____	Thyroid Problems	YES	NO	_____
Glaucoma	YES	NO	_____	TMD/TMJ	YES	NO	_____
Anemia	YES	NO	_____	Jaundice	YES	NO	_____
Heart Attack/Surgery	YES	NO	_____	Tuberculosis	YES	NO	_____
Heart Murmur	YES	NO	_____	Venereal Disease	YES	NO	_____

To the best of my knowledge I have answered the questions completely and accurately. I will inform the dentist of any change in my health and/or medication. I will further certify that I consent to taking x-rays and an oral examination

Patient Signature : _____ Doctor Signature : _____
Date : _____ Date : _____
(Parent if Patient is a Minor)

MEDICAL UPDATE:

- Patient Signature _____ Doctor Signature _____ Date _____
- Patient Signature _____ Doctor Signature _____ Date _____