



Souwell

Dental & Medical Information

Dental History

Name of Last General Dentist: _____

Address: _____ City _____ State _____ Zip _____

Have You Requested for Your Records to be Transferred to Us? *Yes / No*

If No, Would You Like Us to Request Your Records for You? *Yes / No*

Date of Last Dental Visit:: _____ Reason for this visit: _____

When Was Your Last Dental Cleaning? _____ When Were Your Last Dental X-Rays Done? _____

Do You Floss Your Teeth? *Yes / No* If Yes, How Often: _____

What Kind of Toothbrush Do You Use: *Manual / Electric / Both* If Electric, What Make or Model Is It: _____

Have You Ever Had Complications Following Dental Treatment? *Yes / No* If Yes, Please Describe: _____

Have You Been Advised To Take Antibiotics Prior To Dental Treatment? *Yes / No* If Yes, Reason: _____

If Yes What Do You Take: _____

Have You Ever Had A Complication or A Reaction To Dental Anesthetics? *Yes / No* If Yes, Please Describe: _____

Orthodontics

Have You Ever Been to An Orthodontist? *Yes / No*

Have You Ever Had Orthodontic Treatment? *Yes / No* If, Yes When Did You Have Treatment _____

What Type of Treatment Did You Have? *Full Braces / Partial Braces / Retainer Only / Other:* _____

Are You Under The Care of An Orthodontist Now? *Yes / No*

Orthodontist's Name: _____ City _____ State _____ Zip _____

Periodontics

Have You Ever Been To A Periodontist? *Yes / No*

Did You Have Periodontal Treatment? *Yes / No*

What Type of Treatment Did You Have? _____

Are You Under Their Care Now? *Yes / No* If Yes, What Type: _____

Periodontist's Name: _____ City _____ State _____ Zip _____

TMJ – Jaw Joints

Do Your Jaws (TMJ) Pop, Click or Lock? _____ If Yes, Which Side(s) and How Often: _____

Do You Have Pain When you Jaws Pop, Click or Lock? *Yes / No* Which Side(s)? *Right / Left*

Do you currently wear a removable acrylic appliance? *Yes/No*

Pain

Do You Have Dental Pain or Discomfort Other Than TMJ Now? *Yes / No* If Yes, Please Describe: _____



Medical History

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Vascular Heart Disease
Please Describe: _____
_____ | Type(s): _____
<input type="checkbox"/> AIDS
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> Hepatitis D
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes
Type: _____
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Excessive Bleeding
Following Any Surgery or
Injury
<input type="checkbox"/> Fainting
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Growths
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Head Injuries
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Pregnancy
Due date: _____
<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Mouth or Lip Ulcers
How Often Do You Get
Them: _____
Are You Using Anything To
Treat Them: _____
What Are You Using: _____
_____ | <input type="checkbox"/> Venereal Disease

Allergies/ Bad Reactions
to:
<input type="checkbox"/> Penicillin
<input type="checkbox"/> Erythromycin
<input type="checkbox"/> Cephalexin (Keflex)
<input type="checkbox"/> Clindomycin
<input type="checkbox"/> Aspirin
<input type="checkbox"/> NSAIDS – Non-Steroidal
Anti Inflammatory Drugs
<input type="checkbox"/> Codeine products
<input type="checkbox"/> Other: _____

_____ |
|--|---|--|---|

Please List ALL Drugs and Medications You Are Taking (Both Prescription and Non- Prescription Drugs):

Have You Ever Been Treated For Cancer? If Yes, Please Elaborate: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

Are you now under the care of a physician? Yes No

If yes, please explain: _____

Name of Physician(s): _____ Phone: _____

_____ Phone: _____

When did you last visit your physician? _____ Why did you see your physician? _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____