BUIE CLINIC

DENTAL & HEALTH HISTORY

Todays Date:__________________

Patient Name:____ Birthdate:____________________

DENTAL HISTORY

Chief Complaint:____

Former Dentist:_____________________________ Date of last Dental visit:___________________________________

- ☐ Bad Breath
- ☐ Grinding Teeth
- ☐ Bleeding Gums
- ☐ Loose Teeth
- ☐ Broken Fillings
- ☐ Clicking/Popping Jaw
- ☐ Food Collection in teeth
- ☐ Growths or Sores in mouth
- ☐ Periodontal Treatment
- ☐ Sensitivity to cold or hot
- ☐ Sensitivity to Sweets
- ☐ Sensitivity when biting

MEDICAL HISTORY

Physician's Name:____ Date of Last Visit:________________

Have you had any serious illness or operations?__________ If yes, describe:___________________________________

Have you ever had a blood transfusion?_________ if yes, Approximate dates:__________________________________

Have you ever taken any drugs referred to as "fen-phen"? (YES / NO)

(WOMEN) Are you Pregnant? (YES / NO) Nursing? (YES / NO) Taking Birth control? (YES / NO)

Check if you have or have had any of the following:

- ☐ Shortness of Breath
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart valves
- ☐ Artificial Joints
- ☐ Cortisone Treatment
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Swelling of feet or ankles
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Asthma
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Cancer
- ☐ Headache
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Anemia
- ☐ Skin Rash
- ☐ Stroke
- ☐ Glaucoma
- ☐ Thyroid problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List Medications you are currently taking:_______________

____

____

Pharmacy:____

Phone:____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Sulfa
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Latex
- ☐ Other___________

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____ ________________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ________________________

Please Print name of Patient, Parent, Guardian or Personal Representative Date

____ ________________________

Reviewed by Doctor Date