WELCOME to Brite Family Dental

Health Questionnaire Date:_____

Patient's Name:_____ Date of Birth:_____

Physician's Name, Telephone Number:_____

DENTAL

What type of dental treatment do you feel you need?_____

Is there anything about your smile that you would like to change?_____

Are you nervous about having dental treatment? ❒ No ❒ Slightly ❒ Moderately ❒Extremely

Are you in pain or discomfort at this time?.....YES NO

When did you last see a dentist?_____ Who was your previous dentist?_____

Have you ever had a severe reaction to dental treatment or local anesthetics?.....YES NO

Please check (√) any of the following that apply to you:

❒ Bleeding, Sore Gums	❒ Teeth Sensitive to Hot/Cold	❒ Clenching/Grinding Teeth	❒ Unpleasant Breath
❒ Loose Teeth	❒ Food Sticking in Teeth	❒ Clicking/Popping Jaw	❒ Previous Braces
❒ Unpleasant Taste in Mouth	❒ Sweet Sensitivity	❒ Pain in Jaw Joint	❒ Desire Straight Teeth
❒ Missing Teeth	❒ Chipped/Broken Teeth	❒ Frequent Headaches	❒ Desire Whiter Teeth
❒ Mouth/Lip Sores	❒ Biting Sensitivity	❒ Migraines	❒ Desire Fresher Breath
❒ Lumps/Swellings in Mouth	❒ Worn Teeth	❒ Sore Facial/Neck Muscles	❒ Wear Splint/Nightguard
❒ Sleep Apnea	❒ Other, please list:_____		

MEDICAL Please check (√) any of the following that you have had in the past or have at present:

❒ Stroke	❒ Cough with blood	❒ AIDS	❒ Liver disease
❒ Heart failure	❒ Tuberculosis	❒ HIV+	❒ Yellow jaundice
❒ Heart disease or attack	❒ Asthma	❒ Blood Transfusion	❒ Hemophilia
❒ Heart/Chest pain	❒ Seasonal allergies	❒ Venereal disease	❒ Drug/Alcohol addiction
❒ Heart murmur	❒ Sinus trouble	❒ Genital herpes	❒ Hepatitis A, B, C
❒ Artificial heart valve	❒ Emphysema	❒ Kidney disease	❒ Bruise easily
❒ Heart pacemaker	❒ Diabetes	❒ Thyroid disease	❒ Anemia
❒ Heart surgery	❒ Radiation treatment	❒ Cortisone medication	❒ Sickle cell disease
❒ High/Low blood pressure	❒ Chemotherapy	❒ Arthritis	❒ Anxiety
❒ Rheumatic fever	❒ Cancer	❒ Rheumatism	❒ Depression
❒ Artificial joint	❒ Glaucoma	❒ Weight gain/loss	❒ Psychiatric treatment
❒ Special diet	❒ Osteoporosis	❒ Autoimmune disease	❒ Fibromyalgia
❒ Endocarditis	❒ Stomach ulcers	❒ Epilepsy/Seizures	❒ Easily faint/Lightheaded
❒ Botox™, Dermal fillers	❒ Reflux disease/GERD	❒ Other, please list:_____	

Please check (√) any of the following to which you are allergic (i.e., itching, rash, swelling of hands/feet/eyes/tongue) or which make you sick:

❒ Penicillin	❒ Aspirin	❒ Codeine	❒ Sulfa drugs
❒ Latex	❒ Tylenol/Acetaminophen	❒ Ibuprofen	❒ Local anesthetic
❒ Metals (nickel etc.)	❒ Barbiturates	❒ Other, please list:_____	

Have you been under the care of a physician or in the hospital within the past two years?.....YES NO

If Yes, for what conditions?_____

Do you take any medications or drugs (prescribed or over the counter) including aspirin, birth control or supplements?.YES NO

If Yes, please specify name and purpose of medication:_____

_____

OVER: PLEASE FILL OUT THE BACK OF THIS FORM

Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint?.....YES NO
Have you ever had any excessive bleeding requiring special treatment?.....YES NO
Do you smoke or chew tobacco?.....YES NO
If Yes, are you interested in quitting?.....YES NO
Have you ever taken, or are you currently taking drugs without a prescription?.....YES NO
When you walk up stairs or exert yourself, do you ever have to stop due to pain in your chest, shortness of breath or because you are very tired?.....YES NO
Do your ankles swell during the day?.....YES NO
Do you snore or have difficulty breathing while sleeping?.....YES NO
If Yes, have you sought any treatment?.....YES NO
WOMEN: Are you pregnant or suspect you may be pregnant?.....YES NO
If Yes, what is your due date?_____
Do you use oral contraceptives?.....YES NO
Are you nursing?.....YES NO
Have you ever taken Fosamax, Boniva, or any other drug prescribed to decrease bone resorption or any drugs for metastatic bone cancer?.....YES NO

If you have any disease, condition, or concern not mentioned, please list:_____

_____

To the best of my knowledge, all of the preceding answers are accurate. If I ever have a change in my medical condition or in my medications, I will inform the doctor and his associates at the next appointment without fail. I understand the importance that such changes can affect my dental treatment and I assume the responsibility to notify the doctor and his associates.

Signature:_____ Date:_____
(Patient, legal guardian or authorized agent of patient)

(Rev. 8/23)

MEDICAL HISTORY UPDATES

Date	Initials	Changes