Patient History

JAMES P. WELLER DDS

We appreciate you taking the time to complete this medical and dental questionnaire as fully and completely as possible. It is essential that we understand your condition at the outset of treatment to assure your maximum comfort and safety. If you have any question about anything on this form, just ask. And if there is any additional information you think we should have, please do not hesitate to tell us.

Reason for Today's Visit _____

ABOUT YOU

Name _____ Age _____ Date of Last Dental Exam _____

Former Dentist _____ Date of Last Dental X-rays _____

Current Physician _____ Phone _____ Date of Last Visit _____

Please answer the following questions.

1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years? ☐ Yes ☐ No
2. I have a fear of going to the dentist: ☐ None ☐ Low ☐ Medium ☐ High
3. My mouth and teeth are uncomfortable: ☐ Not at all ☐ Moderately ☐ Very
4. I am ☐ Very Satisfied ☐ Satisfied ☐ Dissatisfied with the appearance of my teeth.
5. I think my present state of dental health is ☐ Excellent ☐ Good ☐ Fair ☐ Poor
6. I would say that my main concerns with my dental health are _____
7. I am interested in a smile evaluation and personalized treatment plan to enhance my smile. ☐ Yes ☐ No

DENTAL HISTORY

How often do you brush? _____ How often do you floss? _____

Please check any of the following conditions that apply to you.

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to heat
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

Please continue to the next page. The section below is for office use only.

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it states past and present conditions.

Changes	Patient's Signature	Date
☐ None, or list: _____	X _____	_____
☐ None, or list: _____	X _____	_____
☐ None, or list: _____	X _____	_____

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MEDICAL HISTORY

Women: Are you pregnant? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Please check If you have had any of the following:

☐ AIDS	☐ Congenital Heart Lesions	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Cortisone Treatments	☐ Hernia Repair	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough Up Blood	☐ HIV Positive	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Bleeding Abnormally	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Blood Disease	☐ Headaches	☐ Nervous Problems	☐ Tonsillitis
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tuberculosis
☐ Chemical Dependency	☐ Heart Problems	☐ Psychiatric Care	☐ Ulcer
☐ Chemotheraphy	Describe _____	☐ Radiation Treatment	☐ Venereal Disease
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	

Have you ever taken any of these medications?

Diet Medications:	☐ Dexfenfluramine	☐ Fen-phen	☐ Pondimin	☐ Redux
Blood Thinners:	☐ Coumadin	☐ Warfarin		
Other:	☐ Levoxyl	☐ Synthroid	☐ Fosamax	

☐ Yes ☐ No Are you currently taking any **medications** or herbals? If so, please list everything you are currently taking below.

_____

☐ Yes ☐ No Are you **allergic** to any medications or substances? If yes, please indicate below:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Iodine ☐ Metal ☐ Latex Other _____

☐ Yes ☐ No Have you used tobacco (smoking or chewing)?

If yes, explain: _____

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

If yes, explain: _____

☐ Yes ☐ No Do you have any health problems that were not listed above or need further clarification?

If yes, explain: _____

CERTIFICATION

To the best of my knowledge, all the preceding information is complete and correct. I understand that it is my responsibility to inform Dr. Weller's practice if I, or my minor child, have any change in health or medical condition.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative *Date*

_____ _____

Please Print Name of Patient, Parent, Guardian or Personal Representative *Relationship to Patient*

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