CAMINO HEALTH CENTER

REASON FOR VISIT AND DENTAL HEALTH HISTORY

CONFIDENTIAL

Patient Name _____ Date of Birth _____

For today's Dental visit, please check ALL boxes that apply:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking, popping or locked jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth, broken fillings or crown work
- ☐ Periodontal (gum) treatment
- ☐ Sensitivity to cold, hot, sweet, air (please circle)
- ☐ Sensitivity when biting/chewing
- ☐ Sores, blisters or growth in your mouth
- ☐ Denture problem/question
- ☐ Implant/bridge problems/questions

Do you or your child brush? ☐ Yes ☐ No

Do you or your child floss? ☐ Yes ☐ No

MEDICAL HISTORY UPDATE

Last Medical visit with physician: _____ Physician's name: _____

Has your or your child's health changed in the last 6 months? ☐ Yes ☐ No If Yes, explain _____

Are you or your child currently taking medication? ☐ Yes ☐ No If Yes, list _____

Have you or your child had any serious illness or operations in the last 6 months? ☐ Yes ☐ No If Yes, explain _____

Have you or your child ever had a blood transfusion? ☐ Yes ☐ No

(Adults Only) Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Iomin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) ☐ Yes ☐ No

(Adults Only) Are you taking or scheduled to begin taking either of the following medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No If Yes, how many months _____

Breast feeding? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

ALLERGIES

Do you or your child have any of the following allergies?

- ☐ Latex
- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Patient/Parent/Guardian Signature_____

Date _____Provider Signature_____