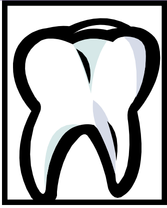
Raptou Family Dental, Inc

Where There's Always More to Smile About!



DENTAL HISTORY

PREVIOUS DENTIST: ____ LAST DENTAL EXAM: ______________________

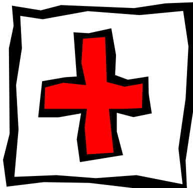
HOW OFTEN DO YOU HAVE YOUR TEETH CLEANED? 3 MO 4 MO 6 MO 1 YEAR +

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **COMMENTS:**

Y N ARE YOU CURRENTLY IN PAIN? ____
Y N ARE YOU HAPPY WITH THE WAY YOUR SMILE LOOKS? ______________________________
Y N HAVE YOU HAD ANY ORTHODONTIC TREATMENT? (BRACES) ___________________________
Y N HAVE YOU HAD ANY PERIODONTAL TREATMENT? (GUMS) ____________________________
Y N DO YOUR GUMS EVER BLEED? ____
Y N ARE YOUR TEETH SORE? ____
Y N DO YOU HAVE DIFFICULTY SWALLOWING? _____________________________________
Y N DO YOU HAVE ANY JAW PAIN? ____
Y N DO YOU CLENCH OR GRIND YOUR TEETH? ____________________________________
Y N DOES YOUR JAW CLICK OR POP? ____
Y N HAVE YOU LOST ANY [PERMANENT] TEETH? ___________________________________
Y N DO YOU STILL HAVE YOUR WISDOM TEETH? ___________________________________
Y N DO YOU HAVE FREQUENT HEADACHES? ______________________________________
Y N DO YOU BRUSH YOUR TEETH DAILY? ____
Y N DO YOU FLOSS DAILY? ____
Y N DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL WORK? ____________________________
Y N HAVE YOU EXPERIENCED PROBLEMS WITH ANESTHETICS? ___________________________
Y N DO YOU HAVE SLEEP APNEA / USE A C.P.A.P. MACHINE / SNORE EXCESSIVELY? _______________

WHAT ONE THING WOULD YOU CHANGE ABOUT YOUR SMILE/TEETH IF YOU COULD? ____________________



MEDICAL HISTORY

NAME OF PHYSICIAN: ______________________________ PHONE #: (   ) ________________________

DATE OF MEDICAL VISIT: __________________ REASON: ____

YOUR CURRENT PHYSICAL HEALTH IS: ____ GOOD ____ FAIR ____ POOR

DO YOU SMOKE OR USE TOBACCO IN ANY OTHER FORM: Y N

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N ASPIRIN
Y N PENICILLIN
Y N CODEINE
Y N SEDATIVES
Y N DENTAL ANESTHETIC
Y N SULFA DRUGS
Y N ERYTHROMYCIN
Y N TETRACYCLINE
Y N IBUPROFEN
Y N LATEX
Y N ACRYLLIC
Y N GLUTEN
Y N OTHER ____________________

FOR WOMEN: ARE YOU ... PREGNANT? Y N ...TAKING ORAL CONTRACEPTIVES? Y N ...NURSING? Y N

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING: ____

HAVE YOU EXPERIENCED/BEEN TREATED FOR ANY OF THE FOLLOWING?

Y N ABNORMAL BLEEDING
Y N ANAPHYLAXIS / SEVERE ALLERGY
Y N ANEMIA
Y N ANGINA / CHEST PAIN
Y N ARTIFICIAL VALVES / JOINTS
Y N ASTHMA / DIFFICULTY BREATHING
Y N BLOOD DISEASE / TRANSFUSION
Y N CANCER/CHEMO / RADIATION
Y N CONGENITAL HEART DISORDER
Y N DIABETES/HYPOGLYCEMIA
Y N FAINTING SPELLS / SYNCOPE
Y N HEART ATTACK / SURGERY
Y N HEART MURMUR / ARRYTHMIAS
Y N HEMOPHILIA/BLEEDING EASILY
Y N HEPATITIS A / B / C (HCV)
Y N HERPES/FEVER BLISTERS
Y N HIGH BLOOD PRESSURE
Y N HIV+ / AIDS
Y N KIDNEY DISEASE
Y N LIVER DISEASE
Y N MITRAL VALVE PROLAPSE
Y N OSTEOPOROSIS
Y N PACEMAKER
Y N RHEUMATIC / SCARLET FEVER
Y N PERSISTENT COUGH
Y N SEIZURES / EPILEPSY
Y N SINUS PROBLEM / SEASONAL ALLERGY
Y N STEROID THERAPY
Y N STROKE
Y N THYROID DISEASE
Y N TUBERCULOSIS (TB)
Y N ULCERS / INTESTINAL DISORDER
Y N OTHER ____________________

MOST IMPORTANTLY, WHO MAY WE THANK FOR REFERRING YOU? ______________________________