REGENCY
FAMILY DENTAL
ADYA SHROTRIYA, DDS

PATIENT HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for today's visit___________________________________
____
____
Are you aware of a problem?______________________________
____
How long since your last dental visit?______________________
What was done at that time? ______________________________
Previous Dentist?_______________________________________
Have you had regular visits? ______________________________
Were dental x-rays taken? ________________________________
Have you lost any teeth?________ Why?___________________
____
____
Do you clench or grind your teeth?_______________________
Does your jaw click or pop? ______________________________

Have you experienced any pain or soreness in the muscles of your face or around the ears? ______________________________
Does food get stuck between your teeth ____________________
Are any teeth sensitive to [ ] hot [ ] cold [ ] sweets [ ] pressure
How often do you brush your teeth _________________________
Do your gums bleed or hurt when brushing __________________
Do you use dental floss _________how often ________________
Do you think you have bad breath _________________________
Are you happy for the appearance of your teeth in general _____
____
Have you had any complications or illness following dental treatment of any kind? ___________________________________
____
Have you ever had a bad reaction to local anesthetic? _________
____

MEDICAL HISTORY

Are you under a physician's care now? [ ] Y [ ] N If yes, please explain: ____
Have you been hospitalized or had a major operation? [ ] Y [ ] N If yes, please explain: ____
Have you ever had a serious head or neck injury? [ ] Y [ ] N If yes, please explain: ____
Are you taking any medications, pills, or drugs? [ ] Y [ ] N Please list medications at the bottom of page
Do you take, or have you taken, Phen-Fen or Redux? [ ] Y [ ] N
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? [ ] Y [ ] N
Are you on a special diet? [ ] Y [ ] N
Do you use tobacco? [ ] Y [ ] N
Do you use controlled substances? [ ] Y [ ] N

Women: Are you….
Pregnant/ Trying to get pregnant? [ ] Y [ ] N
Taking oral contraceptives? [ ] Y [ ] N
Nursing? [ ] Y [ ] N

Please Check [✓] if you have or have had any of the following:

[ ] Anemia	[ ] Cortisone Treatments	[ ] Hepatitis	[ ] Scarlet Fever
[ ] Arthritis, Rheumatism	[ ] Cough, Persistent	[ ] High Blood Pressure	[ ] Shortness of Breath
[ ] Artificial Heart Valves	[ ] Cough up Blood	[ ] HIV/ AIDS	[ ] Skin Rash
[ ] Artificial Joints	[ ] Diabetes	[ ] Jaw Pain	[ ] Stroke
[ ] Asthma	[ ] Epilepsy	[ ] Kidney Disease	[ ] Swelling of Feet or Ankles
[ ] Back Problems	[ ] Fainting	[ ] Liver Disease	[ ] Thyroid Problems
[ ] Blood Disease	[ ] Glaucoma	[ ] Mitral Valve Prolapse	[ ] Tobacco Habit
[ ] Cancer	[ ] Headaches	[ ] Pacemaker	[ ] Tonsillitis
[ ] Chemical Dependency	[ ] Heart Murmur	[ ] Radiation Treatment	[ ] Tuberculosis
[ ] Chemotherapy	[ ] Heart Problems	[ ] Respiratory Disease	[ ] Ulcer
[ ] Circulatory Problems	[ ] Hemophilia	[ ] Rheumatic Fever	[ ] Venereal Disease

Medications

List medications you are currently taking:
____
____
____
____
____
Pharmacy Name:____
Phone: ____

Allergies

Please check all that apply:

[ ] Aspirin [ ] Acrylic
[ ] Penicillin [ ] Metal
[ ] Codeine [ ] Latex
[ ] Local Anesthetics [ ] Sulfa Drugs
[ ] Other: ____

COMMENTS

Is there anything not mentioned above that the Doctor should be aware of? _______________________________
____
____

SIGNATURE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Date:_______________________________ Signature of Patient, Parent, or Guardian ____________________________________