smile GRAND HAVEN

HEALTH AND WELLNESS FORM

PATIENT NAME _____ **DATE** _____

1. ABOUT YOUR DENTAL EXPERIENCE

Why have you come to the dentist today?_____

Are you currently in pain? ☐ Yes ☐ No

What is the most important thing to you about your smile and dental health?_____

_____

Why did you leave your previous dentist? _____

_____

If you could change your smile, you would:
(please check all that apply)

☐ Have a bright white smile

☐ Make your teeth straighter / Close spaces between teeth

☐ Replace silver metal fillings with tooth-colored fillings

☐ Repair chipped teeth

☐ Replace old crowns that don't match

☐ Healthy gums

☐ Fresh breath

On a scale of 1 to 5, with 5 being the highest rating:
(Please circle the number that best applies)

How important is your dental health to you? 1 2 3 4 5

How would you rate your current dental health? 1 2 3 4 5

Has your doctor told you that you require antibiotics before dental treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you have or have you had any of the following?
☐ Dentures ☐ Partial Dentures ☐ Periodontal (gum) Treatment

2. MEDICAL HISTORY/ALLERGIES

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve Date _____
- ☐ Artificial Joint Date_____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spinal Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice
- ☐ Other, unlisted

Please explain_____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Tree Nuts ☐ Other _____

Are you under a physician's care now? ☐ Yes, please explain_____

Have you ever been hospitalized or had a major operation? ☐ Yes, please explain_____

Have you ever had a serious head or neck injury? ☐ Yes, please explain_____

Do you take, or have you taken, Phen-Phen, Redux or Fosamax? ☐ Yes, please explain_____

Are you on a special diet? ☐ Yes, please explain_____

Do you use tobacco? ☐ Yes, please explain_____

Do you use controlled substances? ☐ Yes, please explain_____

Are you taking any medications, pills, or drugs? ☐ Yes, please explain_____

_____

Physician's Name_____

Phone # (_____) _____ Last Visit Date_____

FOR WOMEN

☐ Pregnant / Trying to get pregnant ☐ Taking oral contraceptives ☐ Nursing

Signature _____ Date_____