sonrisa™
a periodental spa

Welcome! So that we may provide you with the best possible care, please complete both dental & medical history form. All information is completely confidential.

Dental History

What is the reason for your visit today?

If referred, what is your dentist's name?

How frequently have you had your teeth cleaned during the past 5 years?

☐Less than once a year ☐Once a year ☐Twice a year ☐Three times a year ☐Four times a year

Date (Mo/Year) of last dental visit Date (Mo/Year) of last dental cleaning

Are you presently satisfied with the condition of your mouth and teeth (check one):

☐Very satisfied ☐Satisfied ☐It's O.K. ☐Somewhat dissatisfied ☐ Very Dissatisfied

YES	NO	Are any of your teeth sensitive to?
☐	☐	Hot or Cold?
☐	☐	Sweets?
☐	☐	Biting or Chewing?

Have you experienced?

☐	☐	Clicking or popping of the jaw?
☐	☐	Difficulty in opening or closing the mouth?
☐	☐	Difficulty in chewing on either side of the mouth?
☐	☐	Aches or pains in your jaw joints, ears, face, neck or head?

Have you ever had?

☐ ☐ Orthodontic treatment? ☐ With braces ☐ With removable appliances

When did you go through orthodontic care?

☐ ☐ Periodontal treatment? ☐Scaling/Root Planing ☐ Gum Surgery

When did you go through Periodontal care?

☐ ☐ Oral Surgery?

☐ ☐ A bite plate or mouth guard?

☐ ☐ A serious injury to the mouth or head?

If YES, please describe:

☐ ☐ Are you concerned about the appearance of your teeth?

☐ ☐ Do your gums ever bleed or hurt?

If YES, when?

☐ ☐ Do you have a problem with bad breath?

☐ ☐ Are you concerned about gum recession around any of your teeth?

☐ ☐ Do you frequently get cold sores, blisters, or any other lesions?

☐ ☐ Do you feel nervous about having dental treatment?

If YES, please describe:

☐ ☐ Is there anything else about having dental treatment that you would like us to know?

If YES, please describe:

Health History

Physician's Name
Address City Phone
Your Age Height Weight Mo/Year of your last medical exam
How would you describe your present health (choose one):
☐Excellent ☐Good ☐Fair ☐Poor ☐Don't Know

YES NO
☐ ☐ Has there been any change in your general heath in the past year?
☐ ☐ Have you had a serious illness, operation or hospitalization during the past 5 years? If YES, please describe:

☐ ☐ Has your M.D. told you to take antibiotics prior to having any type of dental Procedure?
☐ ☐ Have you ever taken orally: Aredia, Zometa, Fosamax, Actonel or any other Bisphosphonates?
☐ ☐ Have you ever taken Pondimin (Fendluramine), Phen-Fen (Phentermine), or Redux For weight reduction?
☐ ☐ Have you ever had excessive bleeding that required special treatment?
☐ ☐ Are you required, due to health, to restrict your work or activity in any way?
☐ ☐ Do you use any kind of tobacco?
If YES, how much? Per day Week Month
☐ ☐ Do you use any kind of Alcohol?
If YES, how much? Per day Week Month
☐ ☐ Do you have any history of substance abuse or do you currently use recreational Drugs?

Check all of the following that you may have had in the past or that currently apply to you:

☐ Heart (Surgery, Disease, Attack)
☐ Chest Pain upon exertion
☐ High/Low blood pressure
☐ Mitral valve prolapse
☐ Congenital heart disease
☐ Rheumatic fever
☐ Heart murmur
☐ Artificial heart valve/Pacemaker
☐ Arthritis/Rheumatism
☐ Diet (Special/Restricted)
☐ Artificial joints (hip, knee, etc.)
☐ Kidney (trouble, disease, impaired function)
☐ Stroke
☐ Received blood transfusion
☐ Impaired liver function
☐ Esophageal reflux
☐ Hiatal hernia
☐ Ulcers
☐ Anorexia or bulimia
☐ Hemophilia
☐ Sickle cell disease
☐ Bruise easily
☐ Psychiatric/ Psychological care
☐ Recurrent infections
☐ Chronic fatigue
☐ Severely impaired vision
☐ Diabetes
☐ Thyroid problems
☐ Irritable bowel syndrome
☐ Glaucoma
☐ Colitis
☐ Emphysema
☐ Chronic cough
☐ Tuberculosis
☐ Asthma
☐ Sinus trouble
☐ Radiation therapy
☐ Chemotherapy
☐ History of cancer
☐ Sleep apnea
☐ Contact lenses
☐ Bronchitis
☐ Heapatis ☐A ☐B ☐C
☐ A.I.D.S/ H.I.V. positive
☐ Cold sores/Fever blisters
☐ Connective tissue disorder
☐ Osteoporosis
☐ Neurological disorders
☐ Epilepsy
☐ Seizures
☐ Nervous/ anxious
☐ Fainting or dizzy spells

Do you have any disease, problem or condition not listed above?
If YES, please explain:_____

_____

_____

Have you lost or gained more than 10 pounds in the past year? ☐Yes ☐No

For Women, check all that are appropriate:
☐I am pregnant ☐I am nursing ☐I am taking birth control pills

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature _____
*Date*_____