DENTAL REGISTRATION AND HISTORY

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DENTAL HISTORY Reason for today's visit Burning sensation on tongue Yes No Mouth breathing Chew on one side of mouth Yes No Mouth pain, brushing Cormer Dentist Cigarette, pipe, or cigar smoking Yes No Pain around ear City/State Dry mouth Yes No Periodontal treatment City/State Dry mouth Yes No Sensitivity to cold Date of last dental visit Food collection between the taeth Yes No Sensitivity to sweets Date of last dental X-rays Foreign objects Yes No Sensitivity to sweets					
Reason for today's visit Burning sensation on tongue Yes No Mouth breathing Chew on one side of mouth Yes No Mouth pain, brushing Cigarette, pipe, or cigar smoking Yes No Orthodontic treatment City/State Dry mouth Yes No Periodontal treatment Citast dental visit Fingernall biting Yes No Sensitivity to cold Date of last dental X-rays Foreign objects Yes No Sensitivity to sweets					
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	Ves No				
Filling to a second sec	Yes No				
nee a man or jes of he to needed it jes	Yes No				
ave had any of the following: Gums swollen or tender Yes No Sores or growths in your mouth ad breath Yes No Jaw pain or tiredness Yes No How often do your flows?	Yes No				

Bleeding gums

Blisters on lips or mouth

Ves No

Yes No Lip or cheek biting

Yes No Loose teeth or broken fillings

How often do you floss?

Yes No How often do you brush?

HEA	ALTH HISTORY

		me

Date of last visit Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. 🗌 Yes 📃 No Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of fonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fentluramine) and Redux (dexdentluramine). Tes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

			the second se					
AIDS/HIV	2 Yes	No	Epilepsy	Yes	No No	Respiratory Disease	Ves	No
Anemia	Yes	No No	Fainting or dizziness	Ves	□ No	Rheumatic Fever	1 Yes	
Arthritis, Rheumatism	2 Yes	🗆 No	Glaucoma	Yes	□ No	Scarlet Fever	T Yes	
Artificial Heart Valves	I Yes	No No	Headaches	Ves	No No	Shortness of Breath	Yes	
Artificial Joints	□ Yes	No No	Heart Murmur	Yes	□ No	Sinus Trouble	Yes	
Asthma	2 Yes	No No	Heart Problems	Yes	□ No	Skin Rash	T Yes	Constant of
Back Problems	Yes	□ No	Hepatitis Type	□ Yes	□ No	Special Diet	T Yes	The second
Bleeding abnormally, with	2 Yes	No No	Herpes	Yes	No	Stroke	Ves	
extractions or surgery			High Blood Pressure	Ves	□ No	Swollen Feet or Ankles	T Yes	
Blood Disease	Ves Ves	□ No	Jaundice	Ves	No	Swollen Neck Glands	I Yes	1.22.12.00.0
Gancer	2 Yes	□ No	Jaw Pain	T Yes	No	Thyroid Problems	Ves	2000
Chemical Dependency	Yes	No No	Kidney Disease	Ves	ALC: NOT THE REAL PROPERTY OF	Tonsillëis	□ Yes	
Chemotherapy	Ves	No.	Liver Disease	T Yes	No	Tuberculosis	Ves	1000
Circulatory Problems	U Yes	□ No	Low Blood Pressure	T Yes	No	Tumor or growth on head or		
Congenital Heart Lesions	Ves	□ No	Mitral Valve Prolapse	Yes	D No	neck	□ Yes	No
Cortisone Treatments	Ves	No No	Nervous Problems	Yes	10005	Ulcer	T Yes	□ No
Cough, persistent or bloody	□ Yes	No No	Pacemaker	1 Yes	D No	Venereal Disease	Ves	No
Diabetes	Yes	No No	Psychiatric Care	☐ Yes	No	Weight Loss, unexplained	T Yes	No
Emphysema	I Yes	No No	Radiation Treatment	□ Yes			1.100	
Do you wear contact lenses?	Yes	No		LI ICO	LI 140			
Women:								
Are you pregnant? [] Yes	No No		Due date	- 8	Are you nu	rsing? 🗆 Yes 🖂 No		

		de south 1			Sec. 1.
Taking I	birth	control	pills?	Yes	No

Are you nursing? Yes No

ALLERGIES

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:	Aspirin Barbiturates (Sleeping pills)	Local Anesthetic Penicillin	
	Codeine	🖸 Sulta	
Pharmacy Name	lodine	Other	
Phone ()	Latex		

UPDATES (To be filled in at future appointments) Has there been any change in your health since your last dental appointment?
Yes No For what conditions? Are you taking any new medications? _____ If so, what? _____ Patient's Signature Date Doctor's Signature. Date Has there been any change in your health since your last dental appointment?
Yes No For what conditions? Are you taking any new medications? _____ If so, what? _____ Patient's Signature Date Doctor's Signature Date