REGINA M. DAILEY, D.M.D.
Dentistry

Dental/Medical History

Patient name:

The following information is needed to enable us to give you the best possible treatment.
In order for the doctor to thoroughly diagnose any condition, she must have accurate answers.
This information is strictly confidential.

Dental History / Information

Former dentist: ______ Tel # ______

Date of last exam: ______ Date of last dental x-rays: ______

Have you been taught a method of brushing/flossing? ❍ Yes ❍ No Other home care: ______

How often do you brush? ______ How often do you floss? ______

Reason for today's visit: ______

Please check any of the following conditions that apply to you:
Please provide details about any positive answers above: ______

- ❍ Clicking or popping TMJ/joint
- ❍ Pain in TMJ/muscle tension in face or joint area
- ❍ Grinding/clenching habit
- ❍ Bad breath
- ❍ Bleeding gums
- ❍ Periodontal treatment
- ❍ Loose teeth or broken fillings
- ❍ Sensitivity to temperatures (hot/cold)
- ❍ Sensitivity to sweets
- ❍ Sensitivity when biting
- ❍ Food collection between teeth
- ❍ Sores or growths in your mouth
- ❍ Swelling in the mouth/neck area
- ❍ Previous injury to mouth or jaw
- ❍ Previous surgery in mouth

Have you ever had an unusual reaction to a dental anesthetic? ❍ Yes ❍ No Explain: ______

Have past dental experiences been satisfactory? ❍ Yes ❍ No Explain: ______

Do you have any concerns/fears about dental treatment? ❍ Yes ❍ No Explain: ______

Do you prefer nitrous oxide with treatment? ❍ Yes ❍ No

Medical History / Information

Physician: ______ Tel # ______

Date of last physical exam: ______

Please list all medications you are currently taking as well as over-the-counter medications, herbal remedies, vitamins, homeopathic remedies:

(Continue on the back of this form, or attach a separate list to this form if necessary.) ______

______

Allergies/reactions to medications or other allergies? ______ ❍ continued…

(Women) Are you pregnant? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No Taking birth control pills? ❍ Yes ❍ No

Do you have a history of the following?

Have you been hospitalized in the past year? ❍ Yes ❍ No Explain:

- ❍ Anemia
- ❍ Arthritis, rheumatism
- ❍ Artificial heart valves
- ❍ Artificial joints
- ❍ Asthma, sinus problems
- ❍ Autoimmune disease
- ❍ Back problems
- ❍ Blood disease
- ❍ Abnormal bleeding, prolonged healing, bruising easily
- ❍ Cancer
- ❍ Chemical dependency
- ❍ Chemotherapy
- ❍ Circulatory problems
- ❍ Cortisone treatments/steroids
- ❍ Cough, persistent/chronic
- ❍ Cough up blood
- ❍ Diabetes
- ❍ Epilepsy/seizures
- ❍ Fainting
- ❍ Glaucoma/eye disorders
- ❍ Headaches, migraine headaches
- ❍ Heart murmur
- ❍ Heart disease (describe)
- ❍ Hepatitis/liver diseases/ jaundice
- ❍ High blood pressure
- ❍ Low blood pressure
- ❍ HIV positive
- ❍ AIDS
- ❍ Kidney disease
- ❍ Mitral valve prolapse
- ❍ Malignancy or tumor/cyst
- ❍ Nervous disorders
- ❍ Pacemaker
- ❍ Psychiatric care
- ❍ Radiation treatment
- ❍ Respiratory disease
- ❍ Rheumatic fever/rheumatic heart disease
- ❍ Shortness of breath
- ❍ Skin rash
- ❍ Stroke
- ❍ Congestive heart failure
- ❍ Thyroid disease
- ❍ Tobacco habit
- ❍ Tuberculosis
- ❍ Ulcer/digestive disorders
- ❍ Venereal disease
- ❍ Hemophilia

______

Are you presently under a physician's care? ❍ Yes ❍ No Explain: ______

Do you consider yourself to be in good health? ❍ Yes ❍ No Explain: ______

Please describe any impending operations, recent injuries or other information the doctor should be aware of: ______

Patient signature ______ Date ______ Doctor's initials ______