AGAPE DENTAL

Patient Name: ______________________________

Date of Birth: ______________________________

Medications:

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Other Health Notes:

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Dates Updated:

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____

Health Conditions:

(Circle all that Apply)

Asthma / Allergy

Asthma   Use Inhaler   Hay Fever   Allergies

Allergic Reactions

Penicillin   Tetracycline   Erythromycin

Sulfa Drugs   Codeine   Dental Anesth.

Aspirin   Ibuprofen   Tylenol

Latex   Reaction to Metals

Barbiturate, Sedatives or Sleeping Pills

Blood Problems

Blood Disease   Easy Bruising   Excessive Bleeding

High Blood Press.   Hemophilia   Prev. Blood Transfusion

Low Blood Press.   Anemia

Heart Problems

Angina/Chest pain   Artificial Heart valve   Blood Pressure

Heart Surgery   Congenital Heart Defect   Pacemaker

Heart Murmur   Mitral Valve Prolapse   Heart Disease

Stroke   Heart Attack   Shortness of Breath

Heart Valve Problem   Rheumatic Fever   Taking Heart Meds

Miscellaneous Health Conditions

Acid Reflux   Drug/ Alcohol Abuse   Frequent Mouth Sores

Nervous Disorders   Swollen Glands   Breathing Difficulty

Dry Mouth   Glaucoma   Persistent Cough   Tuberculosis

Cancer   Radiation Treatment   Emphysema   Growths

Tumors   Colitis   Epilepsy   Hospitalized   Respiratory Problems

Tobacco use   Ulcers   Dizziness   Fainting   Kidney Problems

Shingles   Diabetes   Frequent Headache   Mental Disorder

Sinus Problems   Other______________________________

Liver Disease

Hepatitis   Jaundice   Liver Disorder

STD

Aids   HIV   Herpes/Other

Thyroid

Thyroid Problems   Hypothyroid/Hypothyroid

Joint or Bone Problems

Artificial Joint   Rheumatism   Arthritis

Patient Signature: ______________________________   Date: ______________________

AGAPE
DENTAL

Patient Name: ______________________________

Date of Birth: ______________________________

Last Visit to Dentist: _________________________

Previous Dentist: ____________________________

May we request x-rays?

Yes _____ No _____

Have you ever had complications following dental treatments?

Yes _____ No _____

Have you ever been admitted to a hospital, or needed emergenc care in the last 2 years?

Yes _____ No _____

Are you under care of a Physician?

Yes _____ No _____

Do you have any health problems that need further clarification?

Yes _____ No _____

Name of Physician?

____

Do you have, or have you ever had any of the following:

(Circle all that Apply)

Bleeding, sore gums

Unpleasant taste or bad breath

Burning tongue or lips

Frequent blisters on lips, or in your mouth

Swelling or lumps in your mouth

Clicking or popping of your jaw

Difficulty opening or closing jaw

Loose teeth

Teeth Sensitive to Hot

Sensitive to Cold

Sensitive to sweets

Sensitive to biting

Food Impaction

Clenching or grinding

Shifting of teeth change of bite

Do you like your teeth?

Yes _____ No _____

Oral Hygiene: do you use any of the following?

Brush

Dental Floss

Fluoride Rinse

Other: ________________________

My brush is:

Soft Medium Hard Electric

I would like additional information on:

Bleaching

Cosmetic dentistry

Implants

Naturopathic/Biological Dentistry

Patient Signature: ____________________________________ Date: ________________________________