Oldroyd Family Dentistry

Health and Dental History

Today's Date _____ Appointment Date _____ Time _____

Patient Name : _____ Nickname _____ DOB: _____

Parent:_____ Age (if child):_____ M F

Phone Numbers:

*Home*_____ *Work*_____ *Cell* _____ e-mail _____

Address:_____ ____

City _____ St _____ Zip _____

SSN#_____

How did you hear about us?:_____

Physician's Name _____ Phone #_____

Are you taking any medication now, including regular dosages of aspirin? Yes No

If so, please list name and dosage_____

Are you aware of having an allergic reaction to any medication or substance? Yes No

If so please list _____

Have you been under the care of a medical doctor during the past two years? Yes No

If so, for what? _____

Have you seen an ENT (ear, nose and throat doctor)? Yes No

Name_____

Have you seen a chiropractor? Yes No Name_____

Have you seen a neurologist? Yes No Name_____

Have you had braces? Yes No Name_____

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Concerns	Yes	No	Headaches	Yes	No	Sickle Cell Disease	Yes	No
Congenital Heart Disease	Yes	No	Jaw Pain	Yes	No	Neurological Disorders	Yes	No
Heart Murmur	Yes	No	Jaw Popping	Yes	No	Tingling in arms/fingers	Yes	No
High blood pressure	Yes	No	Limited opening	Yes	No	Insomnia/frequent waking	Yes	No
Mitral Valve Prolapse	Yes	No	Congested ears	Yes	No			
Artificial Heart Valve	Yes	No	Dizziness	Yes	No			
Pacemaker	Yes	No	Ringing Ears	Yes	No	Does food pack or catch	Yes	No

Stroke	Yes	No	Loose Teeth	Yes	No	between your teeth?		
Asthma	Yes	No	Posture Problems	Yes	No	Do your gums bleed?	Yes	No
Liver disease/jaundice	Yes	No	Clenching	Yes	No			
Latex Sensitivity	Yes	No	Grinding	Yes	No	Does your breath	Yes	No
Artificial joints	Yes	No	Facial Pain	Yes	No	concern you?		
Kidney Trouble	Yes	No	Sensitive Teeth	Yes	No			
Radiation/Chemotherapy	Yes	No	Neck Ache	Yes	No	***Doctor Signature:*** _____		
Epilepsy /seizures	Yes	No	Bell's Palsy	Yes	No			
Diabetes	Yes	No	Difficulty Chewing	Yes	No	***Date***: _____		
Hepatitis	Yes	No	Difficulty Swallowing	Yes	No			
AIDS/HIV	Yes	No	Trigeminal Neuralgia	Yes	No			

Do you have or have you had any disease, condition or problem not listed?

_____