San Ramon Valley Dental
Dr. Paul Fillet

HEALTH HISTORY

DENTAL HISTORY

Why have you come to the dentist today? _____

Are your teeth sensitive to heat, cold or anything else? _____

Are you currently in pain? ☐Y ☐N How is your dental health? ☐Good ☐Fair ☐Poor

Do you require antibiotics before dental treatment? ☐Y ☐N

Do you floss daily? ☐Y ☐N Brush Daily? ☐Y ☐N

Type of bristles on your toothbrush? ☐Hard ☐Medium ☐Soft

Do your gums bleed? ☐Y ☐N Do your gums itch? ☐Y ☐N

Ever had periodontal disease? ☐Y ☐N Do you have mobility in your teeth? ☐Y ☐N

Do you still have wisdom teeth? ☐Y ☐N Previous / Present Dentist? _____

Last visit date? _____ Would you like straighter teeth? ☐Y ☐N Whiter teeth? ☐Y ☐N

Are you happy with your smile? ☐Y ☐N If not, what would you change? _____

MEDICAL HISTORY

Do you have a personal physician? ☐Y ☐N Your current health condition? ☐Good ☐Fair ☐Poor

Are you currently under the care of a physician? ☐Y ☐N Explain: _____

Physician's Name: _____

Physician's Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of last visit: _____

Do you smoke or use tobacco in any form? ☐Y ☐N

Have you ever taken Phen-Phen, Redux or Pondimin? ☐Y ☐N

Have you ever taken Bis-Phosphate medications (i.e. Aredia and Zometa)? ☐Y ☐N

For Women: Are you taking birth control pills? ☐Y ☐N Are you pregnant? ☐Y ☐N ☐Unsure

Week #: _____ Are you nursing? ☐Y ☐N

Have you ever experienced any of the following?

Y	N		Y	N		Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Colitis	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	Shingles
☐	☐	Alcohol Abuse	☐	☐	Congenital Heart Defect	☐	☐	Headaches	☐	☐	Low Blood Pressure	☐	☐	Sickle Cell Disease
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Heart Attack	☐	☐	Lupus	☐	☐	Sinus Problems
☐	☐	Arthritis	☐	☐	Difficulty Breathing	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse	☐	☐	Steriod Therapy
☐	☐	Artificial Bones/Joints	☐	☐	Drug Abuse	☐	☐	Heart Surgery	☐	☐	Pacemaker	☐	☐	Stroke
☐	☐	Artificial Valves	☐	☐	Emphysema	☐	☐	Hemophilia	☐	☐	Persistent Cough	☐	☐	Thyroid Problems
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Hepatitis	☐	☐	Psychiatric Problems	☐	☐	Tonsilitis
☐	☐	Blood Transfusion	☐	☐	Ever Hospitalized	☐	☐	Herpes	☐	☐	Radiation Treatment	☐	☐	Tuberculosis (TB)
☐	☐	Cancer	☐	☐	Fainting Spells	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever	☐	☐	Ulcers
☐	☐	Chemotherapy	☐	☐	Fever Blisters	☐	☐	HIV+/AIDS	☐	☐	Scarlet Fever	☐	☐	STD's
☐	☐	Chicken Pox	☐	☐	Glaucoma	☐	☐	Kidney Problems	☐	☐	Seizures	☐	☐	Human Papiloma Virus

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription or over the counter drugs? ☐Y ☐N

If yes, please list: _____

Are you allergic to any of the following?

☐ Aspirin ☐ Barbiturates ☐ Codeine ☐ Dental Anesthetics ☐ Erythromycin ☐ Jewelry/Metals
☐ Latex ☐ Penicillin ☐ Sedatives ☐ Sulfa Drugs ☐ Tetracycline ☐ Other: _____

I confirm that the medical history above states my past and present medical conditions.

Patient Signature: _____ Date: _____