LUX SMILES

Dental Health History

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Date_____

DENTAL HEALTH

Reason for Today's Visit_____ **Date of Last Dental Care**_____

Former Dentist_____ **Date of Last Dental X-rays**_____

Address_____

Check if you have or have had problems with any of the following:

☐ Bad breath	☐ Clicking or popping jaw	☐ Loose teeth	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Food collection between teeth	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Broken fillings	☐ Grinding teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth
☐ Broken or chipped tooth	☐ Loose or lost fillings	☐ Sensitivity to hot	☐ Other:_____

How often for you floss?_____ **How often do you brush?**_____

What would you change about your smile?_____

MEDICAL HISTORY

How would you describe your health?_____ **Date of last medical exam**_____

Name of Physician_____ **City**_____ **State**_____ **Phone** (_____)_____

Have you ever taken any of the group of drugs referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_____

Have you had any major surgery or hospitalization? ☐ Yes ☐ No If yes, give approximate dates_____

(Women) Are you pregnant? ☐ Yes ☐ No Month:_____ **Nursing?** ☐ Yes ☐ No **Taking any birth control pills?** ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe_____

Check if you have or have had any of the following:

☐ Allergies to Metals	☐ Congenital Heart Defect	☐ Heart Murmur	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Cortisone Treatments	☐ Heart Problems	☐ Liver Disease	☐ Skin Rash
☐ Angina Pectoris	☐ Cold Sores	☐ Heart Pacemaker	☐ Liver Disease	☐ Stroke
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ Heart Surgery	☐ Mitral Valve Prolapse	☐ Stroke
☐ Asthma	☐ Cough up Blood	☐ Hemophilia	☐ Neckaches (chronic)	☐ Swelling of Feet or Ankles
☐ Artificial Heart Valves	☐ Diabetes	☐ Hepatitis A (infectious)	☐ Nervousness	☐ Syphilis
☐ Artificial Joints	☐ Epilepsy or Seizure	☐ Hepatitis B (serum)	☐ Pacemaker	☐ Thyroid Problems
☐ Back Problems	☐ Emphysema	☐ Hepatitis C	☐ Psychiatric Treatment	☐ Tobacco Habit
☐ Blood Disease	☐ Fainting/Dizzy Spells	☐ High Blood Pressure	☐ Radiation Treatment	☐ Tonsillitis
☐ Cancer	☐ Glaucoma	☐ HIV/AIDS	☐ Respiratory Disease	☐ Tuberculosis
☐ Chemical Dependency	☐ Gonorrhea	☐ Jaw Pain	☐ Rheumatic Fever	☐ Ulcer
☐ Chemotherapy	☐ Headaches (chronic)	☐ Kidney Disease	☐ Scarlet Fever	☐ Venereal Disease
☐ Circulatory Problems	☐ Heart Failure	☐ Kidney Stones	☐ Shortness of Breath	☐ Yellow Jaundice

Are you now or have you recently been taking any medication, drugs or herbs? ☐ Yes ☐ No

Name of medication	Reason for medication	Date prescribed	Prescribed by

Allergies

☐ Aspiring	☐ Penicillin
☐ Barbiturates	☐ Sulfa
☐ Codeine	☐ Latex
☐ Local Anesthetic	☐ Other_____

Or any information you want the doctor to know?_____

Any health or medication changes from last visit? ☐ Yes ☐ No If yes, describe_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. If I ever have any change in my health, or if my medication changes, I will inform this office at the next appointment without fail.

_____ Patient Signature

_____ Patient Name (Printed)

_____ Date