Cabdental

PATIENTS DENTAL HISTORY

DATE:

PATIENT'S GENERAL INFORMATION:

NAME:

AGE:

BIRTHDATE:

ADDRESS:

CITY:

ZIP CODE:

PHONE:

CELLPHONE:

EMAIL:

OCUPATION:

MARITAL STATUS:

HEALTH HISTORY

ARE YOU CURRENTLY UNDER ANY MEDICAL TREATMENT? YES NO
DOCTOR'S NAME: DIAGNOSIS: MEDICINE NAME:

HAVE YOU SUFFERED ANY SIGNIFICANT DISEASE IN THE LAST 5 YEARS? YES NO
SPECIFY:

HAVE YOU BEEN UNDER SURGERY IN THE LAST 5 YEARS? YES NO
SPECIFY:

ALLERGIC TO ANY ANTIBIOTIC/MEDICINE? YES NO
SPECIFY:

HAVE YOU HAD HEPATITIS? YES NO
SPECIFY:

ASTHMA YES NO
HIGH/LOW BLOOD PRESSURE YES NO
HEART ATTACK YES NO
STOKE YES NO

Cabdental

DO YOU SMOKE YES NO
DO YOU DRINK YES NO
BLOOD CLOTTING DEFECTS YES NO
BLOOD TRANSFUSIONS YES NO
DIABETES YES NO
EPILEPSY YES NO

ARE YOU PREGNANT? YES NO

DENTAL HISTORY

REASON FOR YOUR DENTAL VISIT: _____

HAVE YOU EVER HAD COMPLICATIONS WITH LOCAL ANESTHESIA? YES NO

HAVE YOU HAD ANY NECK, HEAD OR JAW INJURIES IN THE LAST 5 YEARS? YES NO
SPECIFY:

¿DO YOU LIKE YOUR SMILE? YES NO