



History

DALE FAMILY DENTISTRY
Caring for You...and Your Smile!

Kenneth G. Dale, DDS
2241 State Street, Suite C
New Albany, IN 47150
812-945-5100 (Tel) • 812-945-5101 (Fax)
www.DaleFamilyDentistry.com
info@DaleFamilyDentistry.com

Medical History

Physician's Name : _____ Office Phone : _____ Date of Last Exam: _____

	YES	NO	IF YES, PLEASE EXPLAIN BELOW:
◆ Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	_____
◆ Have you ever been hospitalized for any surgical operation or serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
◆ Are you taking any prescription medication(s)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
◆ Are you taking any non-prescription medication or herbal supplements?	<input type="checkbox"/>	<input type="checkbox"/>	_____
◆ Do you smoke, chew, use snuff or any other forms of tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	_____
◆ Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	_____
◆ Are you allergic to any of the following?			
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Metals
<input type="checkbox"/> Acrylic	<input type="checkbox"/> Latex	<input type="checkbox"/> Anesthetics	<input type="checkbox"/> Other _____

◆ Do you have, or have you had, any of the following?

YES	NO	YES	NO	YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Positive	Chemotherapy	Heart Attack	Mitral Valve Prolapse				
Alcoholism	Cold Sores/Fever Blisters	Heart Disease	Nervousness				
Allergies or Hives	Congenital Heart Disease	Heart Surgery	Pain in Jaw Joints				
Anemia	Cosmetic Surgery	Heart Murmur	Psychiatric Care				
Arthritis	Diabetes	Heart Pacemaker	Radiation Treatment				
Artificial Heart Valve	Drug Addiction	Hemophilia	Rheumatic Fever				
Artificial Joints	Epilepsy or Seizures	Hepatitis A (infectious)	Sinus Trouble				
Asthma	Emphysema	Hepatitis B (serum)	Stroke				
Blood Transfusion	Frequent Headaches	High Blood Pressure	Thyroid Disease				
Bruise Easily	Glaucoma	Kidney Trouble	Tuberculosis (TB)				
Cancer	Hay Fever	Liver Disease	Ulcers				

◆ Have you ever had any serious illness not listed above? YES NO _____

◆ Women Only: Are you Pregnant? / Think you might be? Due Date: _____ Nursing? Taking oral contraceptives?

COMMENTS: _____

Dental History

	YES	NO		YES	NO
◆ Do your gums bleed while brushing or flossing?.....	<input type="checkbox"/>	<input type="checkbox"/>	◆ Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
◆ Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	◆ Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
◆ Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	◆ Have you ever had endodontic (root canal) treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
◆ Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	◆ Have you ever had any periodontal (gum) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>
◆ Do you have any sores or lumps in/near your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	◆ Have you had any orthodontic work (braces)?	<input type="checkbox"/>	<input type="checkbox"/>
◆ Have you had any head, neck or jaw injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	◆ Do you have any teeth that you are interested in replacing?.....	<input type="checkbox"/>	<input type="checkbox"/>
◆ Have you ever experienced any of the following problems in your jaw?			◆ Have you ever had instruction on the correct method of		
Clicking?.....	<input type="checkbox"/>	<input type="checkbox"/>	brushing your teeth and the care of your gums?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (Joint, Ear, Side of Face)?	<input type="checkbox"/>	<input type="checkbox"/>	◆ Are you interested in improving the appearance of you		
Difficulty in opening or closing?.....	<input type="checkbox"/>	<input type="checkbox"/>	teeth? (e.g. changing the color, shape, spacing, or rotation)...	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing?.....	<input type="checkbox"/>	<input type="checkbox"/>	◆ Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE



Signature of Patient or Parent if Minor

Date