Robin I. Raub, D.D.S.

Date: ___/___/___

Name: ______________________________ DOB: ___/___/___

Dental History

Date of last dental visit: ___/___/___ Date of last dental x-rays: ___/___/___

How often do you brush? ____________________ How often do you floss? ________________

Have you ever had periodontal treatment / gum surgery? ☐Yes ☐No

Have you had orthodontic treatment? ☐Yes ☐No

Do you wear dentures or partial dentures? ☐Yes ☐No If yes, age of current dentures: ________________

What are you dental concerns? Please check all that apply:

- ☐ Appearance of smile
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lip/mouth
- ☐ Denture discomfort
- ☐ Frequent headaches
- ☐ Grinding/clenching teeth
- ☐ Jaw difficulty
- ☐ Jaw/head injuries
- ☐ Lip/cheek biting
- ☐ Loose teeth or fillings
- ☐ Sensitivity to hot/cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Tooth pain

Medical History

Family Physician: ______________________________ Phone number: (_____) _____ - ________

Are you under a physician's care? ☐Yes ☐No

If yes, what for? ____

Do you smoke or use smokeless tobacco? ☐Yes ☐No If yes, amount and frequency: ________________

Do you use alcohol? ☐Yes ☐No If yes, amount and frequency: ________________

Do you require **premedication** prior to dental treatment? ☐Yes ☐No If yes, for what: ________________

Have you ever had any of the following? Please check all that apply?

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valve
- ☐ Artificial joints
- ☐ Asthma
- ☐ Blood disease
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cortisone medication
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart conditions
- ☐ Heart lesion
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ HIV
- ☐ HPV
- ☐ Jaundice
- ☐ Jaw joint pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Nervousness / depression
- ☐ Pacemaker
- ☐ Pregnant currently
- ☐ Radiation
- ☐ Respiratory
- ☐ Rheumatic fever
- ☐ Rheumatism
- ☐ Scarlet fever
- ☐ Seizures
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Stomach problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal diseases

Are you allergic to any of the following? Please check all that apply:

- ☐ Aspirin
- ☐ Clindamycin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Sulfa
- ☐ Valium
- ☐ Other (please specify)
- ☐ ________________
- ☐ ________________

Please list your medications:

Name:	Used For:	Name:	Used For:

Patient Signature: ______________________________ Doctor Signature: ______________________________