iBrush Family Dental Care

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: _____ PATIENT FIRST NAME: _____

DENTAL HISTORY

Reason for today's visit

Date of last dental visit

Former dentist

Date of last dental x-rays

Please check if you have/had:	Yes	No		Yes	No	
Bad breath	❑	❑	Head, neck, jaw pain, or aches	❑	❑	Have you ever had an allergic reaction to Novocaine, local,
Blisters on lips or mouth	❑	❑	Lip or cheek biting	❑	❑	or general anesthetics? ❑Yes ❑No
Burning sensation on tongue	❑	❑	Loose teeth or broken fillings	❑	❑	If Yes, please explain
Chew on one side of mouth	❑	❑	Mouth breathing	❑	❑	
Cigarette, pipe, or cigar smoking	❑	❑	Orthodontic treatment	❑	❑	
Smokeless tobacco	❑	❑	Nitrous Oxide	❑	❑	
Dry mouth	❑	❑	Periodontal treatment	❑	❑	
Food collection between teeth	❑	❑	Sensitivity to pressure or irritants	❑	❑	Have you ever had trouble from previous dental care?
Clench or grind teeth	❑	❑	(cold, heat, sweets)			❑Yes ❑No If Yes, please explain
Growths or sore spots in your mouth	❑	❑	How often do you floss?			
Gums swollen, tender or bleeding			How often do you brush?			

MEDICAL HISTORY

Physician's name

Date of last visit

Physician's address

Blood Pressure

Have you had any serious illnesses or operations Yes ❑ No ❑ If yes, please describe

Have you ever had a blood transfusion Yes ❑ No ❑ If yes, give approximate dates

(Women) Are you pregnant? Yes ❑ No LJ Due date Nursing? Yes ❑ No ❑ Taking birth control pills? Yes ❑ No ❑

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	❑	❑	Headaches	❑	❑	Slow healing wounds	❑	❑
Anemia	❑	❑	Heart murmur	❑	❑	Stroke	❑	❑
Arthritis, Rheumatism	❑	❑	Heart problems	❑	❑	Swelling of feet or ankles	❑	❑
Artificial heart valves	❑	❑	Hepatitis type	❑	❑	Thyroid problems	❑	❑
Artificial joints	❑	❑	Herpes	❑	❑	Tonsilitis	❑	❑
Asthma	❑	❑	High blood pressure	❑	❑	Tuberculosis	❑	❑
Required Hospitalization	❑	❑	HIV/AIDS	❑	❑	Tumor or growth on head/neck	❑	❑
Have you used steroids	❑	❑	Jaundice	❑	❑	Ulcer	❑	❑
Date of last episode	❑	❑	Kidney disease	❑	❑	Venereal disease	❑	❑
Bleeding abnormally with operations or surgery	❑	❑	Low blood pressure	❑	❑	Weight loss, unexplained	❑	❑
Blood disease, clotting disorders	❑	❑	Mitral valve prolapse	❑	❑	Do you wear contact lenses?	❑	❑
Cancer	❑	❑	Osteoporosis	❑	❑	Do you consume alcoholic beverages?	❑	❑
Chemical dependency	❑	❑	Osteopenia	❑	❑	Are you currently under the care of a Physician?	❑	❑
Chemotherapy	❑	❑	Pacemaker	❑	❑	Are you allergic/sensitive to Latex?	❑	❑
Circulatory problems	❑	❑	Radiation treatments	❑	❑	Allergic to Penicillin, Aspirin, or other drugs?	❑	❑
Cortisone treatments	❑	❑	Respiratory disease	❑	❑	*If Yes, please specify*		
Cough, persistent or bloody	❑	❑	Rheumatic fever	❑	❑			
Diabetes	❑	❑	Scarlet fever	❑	❑			
Emphysema	❑	❑	Shortness of breath	❑	❑	List any medications that you are taking:		
Epilepsy	❑	❑	Sinus trouble	❑	❑			
Fainting	❑	❑	Sickle cell anemia	❑	❑			
Glaucoma	❑	❑	Skin rash	❑	❑			

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature Date

Reviewed by: Date

CHART - L3 (01-2014)

DENTAL & MEDICAL HEALTH HISTORY