Treman & Treman DENTAL CARE

1989 - 2016
27 Years Of Excellence

Treman & Treman DDS PA

HEALTH HISTORY

Excellent oral health is essential to your general health and well being. It is our goal to help you, as our patient, understand how significantly your dental health affects your overall physical health and vice-versa. Your regular dental exams will provide the opportunity to look for periodontal disease (an active infection present in gum tissue), cavities, oral cancer . . . all conditions that are linked to diabetes, heart disease, stroke and other serious health problems. We are committed to helping you greatly *decrease* your chances of suffering from these debilitating and oftentimes life-threatening diseases, The answers to these questions enable us to assess risk factors in order to provide you with better treatment recommendations that are specific to you. ***Excellent dental and physical health, coupled with a beautiful, bright, well-functioning natural smile are vital goals you and Dr. Treman can work toward together.***

Name_____ Birth Date_____ Age_____

Home Phone_____Cell_____Work_____Email_____

Address_____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated?		
3. Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, explain		
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
5. (Women) Are you pregnant? If so, give due date	☐	☐
6. Do you use tobacco in any form? If yes, how much	☐	☐
7. Do you use alcoholic beverages (more than 2 drinks per day)?	☐	☐
8. Have you recently traveled out of the country?	☐	☐

9. Do you have or have you ever had any of the following?

	YES	NO
GENERAL		
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
SKIN		
Eruptions (rash) hives	☐	☐
Change in skin color	☐	☐
EYES		
Visual change	☐	☐
Glaucoma	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐
RESPIRATORY		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other	☐	☐
BONE/MUSCLES		
Arthritis/rheumatism	☐	☐
Artificial joints/limbs	☐	☐

	YES	NO
HEART/BLOOD VESSELS		
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Other	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
Black, bloody or pale stools	☐	☐
URINARY		
Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urination	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐
BLOOD		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
OTHER		
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
HIV+	☐	☐
AIDS	☐	☐

PLEASE COMPLETE REVERSE SIDE

10. Have you ever been treated for osteoporosis?
If so, please list the medication and whether it was/is oral or IV therapy_____

11. Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO		YES	NO
Local anesthetics (e.g. novocaine)	☐	☐	Aspirin or codeine	☐	☐
Barbiturates/sedatives/sleeping pills	☐	☐	Sulfa drugs	☐	☐
Penicillin/other antibiotics	☐	☐	Other allergies	☐	☐

***If yes to any of the above, please list the drug and describe your reaction.** _____

_____

12. Are you taking any of the following?

	YES	NO		YES	NO
Antibiotics/sulfa drugs	☐	☐	Tranquilizers	☐	☐
Blood thinners	☐	☐	Insulin/other diabetes drugs	☐	☐
Blood pressure medication	☐	☐	Recreational drugs	☐	☐
Thyroid medicine	☐	☐	Digitalis/other heart medications	☐	☐
Cortisone/steroids	☐	☐	Nitroglycerin	☐	☐
Antihistamines/allergy drugs/cold remedies	☐	☐	Aspirin	☐	☐
			Other medication_____		

If yes to any of the above, list ***name*** of medication and ***dosage*** below:
1. _____
2. _____
3. _____
4. _____

13. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

_____

14. Physician's Name _____Phone_____
15. Describe any previous problems you have had with past dental treatment. _____

_____
16. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____
17. Date of last dental visit _____
18. Have you ever been treated for periodontal disease (gum disease)?
If so, when? _____
19. Are you allergic to latex? _____
20. Do you have or have you ever had any of the following?

MOUTH	YES	NO	**TEETH**	YES	NO
Bleeding, sore gums	☐	☐	Loose teeth	☐	☐
Unpleasant taste/bad breath	☐	☐	Sensitive to hot	☐	☐
Burning tongue/lips	☐	☐	Sensitive to cold	☐	☐
Frequent blisters, lips/mouth	☐	☐	Sensitive to sweets	☐	☐
Swelling/lumps in mouth	☐	☐	Sensitive to biting	☐	☐
Ortho treatments (braces)	☐	☐	Food impaction	☐	☐
Biting cheeks/lips	☐	☐	Clenching/grinding	☐	☐
Clicking/popping jaw	☐	☐	Shifting of teeth	☐	☐
Difficulty opening or closing jaw	☐	☐	Change in bite	☐	☐

ORAL HYGIENE

Do you use the following?	YES	NO
Brush	☐	☐
Dental floss	☐	☐
Fluoride rinse	☐	☐
Other _____		

How often do you brush? _____
Brush is: Soft ☐ Medium ☐ Hard ☐

Are there special areas of concern you would like to have addressed by Dr. Treman and his staff?_____

_____

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient
Parent, or Guardian _____ Date _____

PLEASE DO NOT WRITE BELOW THIS LINE

Reviewed By _____ Date _____