WELCOME TO OUR FAMILY OF PATIENTS

IAN H. RODD D.D.S.

Please take a few minutes to answer the following questions to help my staff and I give you the best dental care available.

PATIENT NAME_____ **DATE**_____

Do you have a specific dental problem? If yes, please describe _____ ❑ Yes ❑ No _____
Do you have active decay or gum disease? If yes, please describe _____ ❑ Yes ❑ No _____
Do your gums ever bleed? If yes, please describe _____ ❑ Yes ❑ No _____
Do you brush and floss on a routine basis? How often? _____ ❑ Yes ❑ No _____
Do you have dental examinations on a routine basis? _____ ❑ Yes ❑ No _____
When did you last have a dental examination and x-rays? _____
Does food catch between your teeth? Any loose teeth? _____ ❑ Yes ❑ No _____
Do you ever have clicking, popping or discomfort in the jaw joint? Do you grind your teeth? _____ ❑ Yes ❑ No _____
Do you smoke or chew? Any sores or growths in your mouth? _____ ❑ Yes ❑ No _____
Have your experiences in a dental office always been positive? If not, please discuss with Dr. Rodd. ❑ Yes ❑ No _____
Do you like the appearance of your smile? _____ ❑ Yes ❑ No _____
Do you have concerns about bad breath? _____ ❑ Yes ❑ No _____
Are you under a physician's care now? If yes, please explain. _____ ❑ Yes ❑ No _____
Have you ever been hospitalized or had a major operation? _____ ❑ Yes ❑ No _____
Have you ever had a serious injury to your head or neck? _____ ❑ Yes ❑ No _____
Are you taking any medications, pills or drugs? Please list: _____ ❑ Yes ❑ No _____

Are you allergic to any medication or substances? Please check box below.

❑ Penicillin ❑ Aspirin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Other

Women (Please check if your are): ❑ Pregnant/trying to get pregnant ❑ Nursing ❑ Taking oral contraceptives

Do you now have or have you ever had any of the following? Please check appropriate boxes **BELOW.**
*if yes to any of the starred conditions, ...premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	❑	❑	Artificial Joint*	❑	❑	Tuberculosis	❑	❑	Yellow Jaundice	❑	❑	Cold Sores	❑	❑
Heart Murmur*	❑	❑	Anemia	❑	❑	Cancer	❑	❑	Kidney Problems	❑	❑	Fever Blisters	❑	❑
Irregular Hear Beat	❑	❑	Excessive Bleeding	❑	❑	X-Ray Treatments	❑	❑	Renal Dialysis	❑	❑	Herpes	❑	❑
Angina / Chest Pain	❑	❑	Sickle Cell Disease	❑	❑	Chemotherapy	❑	❑	Thyroid Disease	❑	❑	Stroke	❑	❑
Heart Attack/Failure	❑	❑	Hemophilia(Bleeding Problem)	❑	❑	Stomach/Intestinal Disease	❑	❑	Parathyroid Disease	❑	❑	Convulsions	❑	❑
Congenital Heart Disorder	❑	❑	Leukemia	❑	❑	Ulcers	❑	❑	Arthritis/Gout	❑	❑	Epilepsy of Seizures	❑	❑
Mitral Valve Prolapse*	❑	❑	Recent Blood Transfusion	❑	❑	Recent Weight Loss	❑	❑	Rheumatism	❑	❑	Fainting or Dizziness	❑	❑
Scarlet Fever	❑	❑	Swelling of Limbs	❑	❑	Frequent Diarrhea	❑	❑	Pain in Jaw Joints	❑	❑	Glaucoma	❑	❑
Rheumatic Fever*	❑	❑	Breathing Problem	❑	❑	Diabetes	❑	❑	Cortisone Medicine	❑	❑	Tumors or Growths	❑	❑
Artificial Heart Valve*	❑	❑	Shortness of Breath	❑	❑	Excessive Thirst	❑	❑	Bruise Easily	❑	❑	Nervousness	❑	❑
Heart Pace Maker*	❑	❑	Frequent Cough	❑	❑	Hypoglycemia	❑	❑	Venereal Disease	❑	❑	Psychiatric Care	❑	❑
Heart Surgery	❑	❑	Hay Fever	❑	❑	Liver Disease	❑	❑	AIDS	❑	❑	Alzheimer's Disease	❑	❑
High Blood Pressure	❑	❑	Sinus Trouble	❑	❑	Hepatitis A (Infectious)	❑	❑	HIV Positive	❑	❑	Allergies(Medicines)	❑	❑
Low Blood Pressure	❑	❑	Asthma	❑	❑	Hepatitis B or C	❑	❑	Genital Herpes	❑	❑	Allergies(Pollen / Dust)	❑	❑
Blood Disease	❑	❑	Emphysema	❑	❑	Night Sweats	❑	❑	Drug Addiction	❑	❑	Hives or Rash	❑	❑

Have you ever had any other serious illness not checked above? ❑No ❑Yes Please Discuss_____

To the best of my knowledge, all the preceding answers are correct. Any changes in my health status will be shared with the Dental Staff at the next appointment without fail.

X _____ **Date**_____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor Rodd _____ **Date**_____

Medical Updates

REVIEWS BY	DATE	EXCEPTIONS		PATIENT'S SIGNATURE
_____	_____	None ❑	_____	_____
_____	_____	None ❑	_____	_____
_____	_____	None ❑	_____	_____