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DENTAL HISTORY

Your current dental health is: Excellent Good Fair Poor

Are you apprehensive about dental treatment? If so, what are your concerns? _____

Reason for today's visit? _____ Date of last visit _____

Describe any dental problems or concerns _____

- | | | |
|-----|----|---|
| Yes | No | Have you ever had periodontal treatment? |
| Yes | No | Have you ever had root planing (deep cleaning) done? |
| Yes | No | Are your gums red, swollen, glossy or tender? |
| Yes | No | Do your gums bleed or hurt? |
| Yes | No | Do you have a bite plate or mouth guard? |
| Yes | No | Do you have clicking, popping or pain in your jaw? |
| Yes | No | Do you clench or grind your teeth? |
| Yes | No | Do you experience headaches, neck aches or shoulder aches? |
| Yes | No | Do you suffer from migraine headaches? |
| Yes | No | Do you have difficulty opening or closing your mouth? |
| Yes | No | Have you experienced a serious injury to the mouth or head? |

HEALTH HISTORY

Check if you have or have had any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergic or other reaction to |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Tumor or growth | <input type="checkbox"/> local anesthetics |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Kidney trouble or dialysis | <input type="checkbox"/> aspirin |
| <input type="checkbox"/> Rheumatic heart disease/fever | <input type="checkbox"/> Persistent swelling in neck | <input type="checkbox"/> penicillin or other |
| antibiotics | | |
| <input type="checkbox"/> Damaged heart valve | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> sulfa drugs |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> sedatives |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Cancer | <input type="checkbox"/> codeine |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Problems with immune system | <input type="checkbox"/> other |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Tobacco/alcohol use |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Artificial joint replacement | <input type="checkbox"/> Hepatitis, jaundice, liver disease | |

Please list all medications you are taking _____

To the best of my knowledge, the above information is current and accurate. I understand that it is my responsibility to inform the doctor of any changes in my health.

Signature of patient, parent or Personal Representative

Date