Westheimer Lakes Dental
Rose Vuong, DDS

Your general health problems or medications could have an interference with the dentistry that you will receive
Thank you for answering the following questions

Patient _____ Date of Birth _____ Date _____

DENTAL HISTORY

Purpose of initial visit? _____

	Yes	No		Yes	No
Are your teeth sensitive to hot or cold?	☐	☐	History of frequent headaches?	☐	☐
Are your teeth sensitive to sweets?	☐	☐	Do you clench or grind your teeth?	☐	☐
Do your gums bleed?	☐	☐	Do you bite your lip or cheek?	☐	☐
Do you have periodontal disease?	☐	☐	Have you had orthodontic work?	☐	☐
Do you have pain in any of your teeth?	☐	☐	History of prolonged bleeding?	☐	☐
Do you have any mouth sores or inflamed areas?	☐	☐	History of difficult extractions?	☐	☐
Have you had head, neck or jaw injuries?	☐	☐	History of reaction the dental numbing medication?	☐	☐
Have you experienced any of these jaw problems?	☐	☐	Do you floss routinely?	☐	☐
a) Clicking	☐	☐	Do you smoke or chew?	☐	☐
b) Pain (joint, ear, side of face)	☐	☐	Do you like your smile?	☐	☐
c) Difficulty opening or closing mouth	☐	☐			
d) Difficulty chewing	☐	☐			
e) Chew on one side of your mouth	☐	☐			

Name of previous dentist (optional) _____
Date of last full mouth x-ray (16 films or panoramic) _____

MEDICAL HISTORY

PHYSICIAN _____ DATE OF LAST EXAM _____
Have you been hospitalized or had surgeries? List
_____
Have you had a serious accident involving your head or jaw? _____
Are you allergic to any medications or substances? Check below
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Other_____
Women (please check) ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking birth control pills_____

Do you now have or have you ever had any of the following: Please check appropriate boxes
If yes to any of the starred conditions, please call prior to your appointment: premedication may be required

	Yes	No		Yes	No		Yes	No
Heart trouble/Disease	☐	☐	Arthritis/Rheumatism	☐	☐	Epilepsy/Convulsions	☐	☐
Heart murmur or Defect*	☐	☐	Tumors or Growths	☐	☐	Anemia	☐	☐
Mitral Valve Prolapse*	☐	☐	Hepatitis, Jaundice liver disease	☐	☐	Steroid Treatment	☐	☐
Pacemaker	☐	☐	HIV virus/AIDS	☐	☐	Radiation Treatment	☐	☐
Stroke	☐	☐	Asthma	☐	☐	Stomach Disease	☐	☐
High Blood Pressure	☐	☐	Fainting/Dizzy Spells	☐	☐	Intestine Disease	☐	☐
Low Blood Pressure	☐	☐	Blood Disease	☐	☐	Tuberculosis	☐	☐
Respiratory Disease	☐	☐	Kidney Disease	☐	☐	Eye Surgery	☐	☐
Rheumatic Fever	☐	☐	Venereal Disease	☐	☐	Joint replacement/Implant*	☐	☐
Diabetes	☐	☐	Thyroid Disease	☐	☐	Tumors or Cancers	☐	☐
Herpes	☐	☐	Alzheimer's disease	☐	☐	Chemotherapy (cancer/leukemia)	☐	☐

Have you had any other serious illness not checked above/Discuss_____
Please List any medications you take including non-prescription drugs: _____

To the best of my knowledge the above answers are correct. If I have any changes in my health status or medications, I shall inform the Dentist/ Staff

X_____ Date_____
Patient/Parent or Guardian