ROBERT W. HAAG, DDS

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DENTAL HISTORY

Patient Name	Medical Alert

What is the reason for your visit today?

Date of last dental visit	Last dental cleaning	Last full mouth x-rays

What was done at your last dental visit?

Previous dentist's name, address, phone

How often do you have dental examinations?

How often do you brush your teeth?	How often do you floss?

What other dental aids do you use? (Interplak, toothpick, etc…)

Do you have any dental problems now? **Yes** **No** If yes, please describe:

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Have you noticed any odors or bad tastes?	Yes	No
Do you frequently get cold sores, Blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where _____

Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign object with your teeth? (pencils, pipes, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:		
Orthodontics treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you ever experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side on the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No

Do you feel nervous about having dental treatment? Yes No If so, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience? Yes No If yes, please describe _____

_____

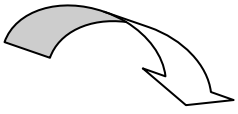
Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

_____

_____



Please Turn Over and Complete Reverse Side

ROBERT W. HAAG, DDS

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

MEDICAL HISTORY

Patient Name	Medical Alert		
Primary physician's name (internist, family practice, etc…)	Phone		
Address	City	State	Zip

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, for what? _____
   Physician's name _____ Phone _____
   Address _____ State _____ Zip _____
2. Are you taking any medication, drugs, or pills now, including regular dosages of aspirin? Yes No
   If yes, please list name and dosage _____
3. Are you aware of having an allergic (**or adverse**) reaction to any medication or substance? Yes No
   If yes, please list _____
4. Have you been a patient in the hospital during the past five years? Yes No
5. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (Infectious) B (Serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (Hip, Knee, Etc)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

6. Do you use more than two pillows to sleep? Yes No
7. Have you lost or gained more than 10 pounds in the past year? Yes No
8. Do you have or have you had any disease, condition, or problem not listed? Yes No
9. Women:
   Are you: Pregnant? Yes (____months) No Nursing? Yes No Taking Birth Control Pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____