

MEDICAL HISTORY & CHARTING

Stephen J Rouse DMD MS

Date

Name S.S.#

Address HOME PHONE

City Zip BUSINESS PHONE

Employed By: Present Occupation

Address City Zip

Person Responsible for your account: Relationship

Dentist Address

Physician Address

Dental Insurance: Yes No Insurance Company Cell Phone

Referred By: Birthday

MEDICAL HISTORY

	(✓) Yes	No
Have you ever had:		
Hepatitis		
Epilepsy		
Rheumatic Fever		
Kidney Disease		
Diabetes		
Liver Disease		
Tuberculosis		
Heart Trouble		
Heart Murmur		
High Blood Pressure		
Shortness of Breath		
Chest Pains		
Allergies: penicillin, codeine		
Medical treatment by X-Ray		
Ulcers or Stomach Trouble		
Surgery		
Glaucoma		
Thyroid or Parathyroid Disorder		
Drug Reaction		
Any serious illness not listed		

	(✓) Yes	No
Are you:		
Presently under the care of a physician?		
Taking any medication now? or within past year?		
Allergic to dental anesthetic?		
Aware of recent weight change?		
Subject to frequent urination?		
Often thirsty?		
Often exhausted or fatigued?		
Subject to frequent headaches?		
Excessively nervous?		
In good health now?		
Do you smoke?		
How much?		
Does anyone in your family have diabetes?		
Do you have prolonged bleeding after injury or tooth extraction?		
If female, are you now:		
Pregnant?		
Taking anti-pregnancy drug?		
Presently in the menopause?		
Post menopause		

DENTAL HISTORY

	(✓) Yes	No
Mouth Breathing		
Bleeding Gums		
Trench Mouth		
Pyorrhea		
Grinding Teeth		
Sore Teeth		
Clenching		
Shifting Teeth		
Loose Teeth		
Difficulty opening or closing mouth		
Receding Gums		
Jaw joint pain		
Halitosis		
Past Periodontal Treatment		
Past Orthodontic Treatment		
Frequency of Brushing		
Type Toothbrush (hard, etc.)		
Other Dental Aid (floss, toothpick)		
Frequency of Dental Visits		
Frequency of Professional cleaning		
Reasons for Extractions		

SUMMARY (Medical)

Blood Pulse

Medications

Other

DENTAL

1. Chief complaint
2. Duration of complaint
3. In your opinion what is your general dental condition?
4. Are you conscious of your teeth in any way? Satisfied with the way they look?

Signature

Clinical Information

1. Diagnosis: Type case 4500 4600 4700 4800
2. Prognosis: Good _____ Fair _____ Questionable _____ Hopeless _____
3. O.H.: Excellent Good Fair Poor
4. Calculus: Supragingival = slight moderate heavy Subgingival = slight moderate heavy
5. Parafunctional: Bruxing clenching other _____
6. TMJ discomfort: yes no

Charting on back side