James D. Spalenka, D.D.S. **DENTAL HISTORY**

Reason for today's visit_____Date of last dental visit_____
Former Dentist_____Date of last dental x-rays_____

Check any of the following that apply:

___Bad breath	___Grinding teeth	___Sensitivity to hot
___Bleeding gums	___Loose teeth/broken fillings	___Sensitivity to sweets
___Clicking or popping jaw	___Periodontal treatment	___Sensitivity when biting
___Food collection between teeth	___Sensitivity to cold	___Sores/growth in your mouth

How often do you floss?_____How often do you brush?_____
Does dental treatment make you nervous/anxious?_____
Would you like to retain your teeth as long as possible?_____
Are you in pain at this time?_____
Are you satisfied with the appearance of your teeth?_____If not what would you like to change? _____
_____

MEDICAL HISTORY

Physician's name_____Date of last visit_____

Have you had any serious illnesses or operations? ___yes___no Please describe:_____
_____

Have you ever taken any of the group of drugs referred to as "fen-phen"? Including any combinations of Lonimim,Adipex, Fastin(brand names of phentermine), Pondimin (fenfluramine) and Redux(Dexfenfluramine)?___yes___no

Are you or have you ever taken Actonel or Fosomax (bisphosphonates)?___yes___no
Are you pregnant___yes___no Nursing___yes___no Taking birth control pills___yes___no

Please list any medications you are taking:_____
_____

Check any of the following that apply:

___Anemia	___Fainting	___ Radiation Treatment
___Arthritis, Rheumatism	___Glaucoma	___Respiratory Disease
___Artificial Heart Valves	___Headaches	___Rheumatic Fever
___Artificial Joints	___Heart Murmur	___Scarlet Fever
___Back Problems	___Heart Problems	___Shortness of Breath
___Blood Disease	___Hemophilia	___Skin Rash
___Cancer	___Hepatitis	___Stroke
___Chemical Dependency	___High Blood Pressure	___Swelling of Feet/Ankles
___Chemotherapy	___HIV/AIDS	___Thyroid Problems
___Circulatory Problems	___Jaw Pain	___Tobacco Habit
___Cortisone Treatments	___Kidney Disease	___Tonsilitis
___Cough-Persistent/blood	___Mitral Valve Prolapse	___Tuberculosis
___Diabetes	___Pacemaker	___Ulcer
___Epilepsy	___Radiation Treatment	___Venereal Disease

I have completed the above health history truthfully and confirm that it adequately states past and present conditions. I understand that a truthful Health History is essential to the Doctor in being able to provide the best possible care.

_____ _____ _____
Date Signature-Patient/Parent/Guardian Doctor's Initials

Medical History Updates:

_____ _____ _____
Date Signature-Patient/Parent/Guardian Doctors Initials

_____ _____ _____
Date Signature-Patient/Parent/Guardian Doctor's Initials