EMPOWER DENTAL
Rebecca Orsini, D.M.D.

Dental Health History

WHAT CONCERN BROUGHT YOU IN TO OUR OFFICE TODAY?

TODAY'S DATE:

DENTAL HISTORY

Y	N	CONDITIONS	NOTES:
		EXPERIENCE BLEEDING GUMS?	
		HAVE SORES OR ULCERS?	
		WEAR DENTURES OR PARTIALS?	
		MISSING TEETH?	
		DOES FOOD COLLECT BETWEEN TEETH?	
		HAVE SENSITIVITY TO COLD / HOT?	
		EXPERIENCE DAYTIME SLEEPINESS?	
		EXPERIENCE SNORING?	
		HAVE A CPAP?	
		HOW LONG SINCE LAST DENTAL VISIT?	
		DESCRIBE PREVIOUS DENTAL EXPERIENCE:	
		OTHER?	

PHYSICIAN / PHARMACY INFORMATION

PHYSICIAN'S NAME: PHYSICIAN'S PHONE:

PHARMACY: PHARMACY PHONE:

Y	N	CONDITIONS	Y	N	N
		(WOMEN) TAKING BIRTH CONTROL PILLS?			(WOMEN) ARE YOU NURSING?
		(WOMEN) ARE YOU PREGNANT?			IF YES, # OF WEEKS_____
		DO YOU SMOKE OR USE TOBACCO?	HEIGHT:		WEIGHT:
BP			HEART RATE:		

MEDICATIONS

LIST MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION	DOSE	REASON

IS THERE ANY DISEASE, CONDITION OR PROBLEM THAT YOU THINK THIS OFFICE SHOULD KNOW ABOUT THAT IS NOT MENTIONED? IF YES, PLEASE DESCRIBE BELOW: