(PLEASE PRINT)

Cooper Owens DDS

Patient Information

Date _____

Social Security # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Home (_____) _____

Best Phone Number (_____) _____

E-mail _____

Birth date _____

Patient Employer/School _____

Occupation _____

Whom may we thank for referring you? _____

Dental History

Reason for today's visit _____
_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

Place a mark on "yes" or "no" to indicate if you every had any of the following:

Bad Breath	❑ Yes	❑ No
Bleeding Gums	❑ Yes	❑ No

Blisters on lips or mouth	❑ Yes	❑ No
Burning sensation on tongue	❑ Yes	❑ No
Chew on one side of mouth	❑ Yes	❑ No
Cigarette, pipe, or cigar smoking	❑ Yes	❑ No
Clicking or popping jaw	❑ Yes	❑ No
Dry mouth	❑ Yes	❑ No
Fingernail biting	❑ Yes	❑ No
Food collection between the teeth	❑ Yes	❑ No
Foreign Objects	❑ Yes	❑ No
Grinding teeth	❑ Yes	❑ No
Gums swollen or tender	❑ Yes	❑ No
Jaw pain or tiredness	❑ Yes	❑ No
Lip or cheek biting	❑ Yes	❑ No

Loose teeth or broken fillings	❑ Yes	❑ No
Mouth breathing	❑ Yes	❑ No
Mouth pain, brushing	❑ Yes	❑ No
Orthodontic treatment	❑ Yes	❑ No
Pain around ear	❑ Yes	❑ No
Periodontal treatment	❑ Yes	❑ No
Sensitivity to cold	❑ Yes	❑ No
Sensitivity to heat	❑ Yes	❑ No
Sensitivity to sweets	❑ Yes	❑ No
Sensitivity when biting	❑ Yes	❑ No
Sores or growths in your mouth	❑ Yes	❑ No

How often do you floss? _____

How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brad names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ❑ Yes ❑ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ❑ Yes ❑ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No
Bleeding abnormally, with extractions or surgery	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No
Circulatory Problems	❑ Yes	❑ No
Congenital Heart Lesions	❑ Yes	❑ No
Cortisone Treatments	❑ Yes	❑ No
Cough, persistent or bloody	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No

Do you wear contact Lenses?	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No
Fainting or dizziness	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Headaches	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
Heart Problems	❑ Yes	❑ No
Hepatitis Type _____	❑ Yes	❑ No
Herpes	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Jaundice	❑ Yes	❑ No
Jaw Pain	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No
Liver Disease	❑ Yes	❑ No
Low Blood Pressure	❑ Yes	❑ No
Mitral Valve Prolapse	❑ Yes	❑ No
Nervous Problems	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No
Psychiatric Care	❑ Yes	❑ No

Radiation Treatment	❑ Yes	❑ No
Respiratory Disease	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Scarlet Fever	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
Sinus Trouble	❑ Yes	❑ No
Skin Rash	❑ Yes	❑ No
Special Diet	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
Swollen Feet or Ankles	❑ Yes	❑ No
Swollen Neck Glands	❑ Yes	❑ No
Thyroid Problems	❑ Yes	❑ No
Tonsillitis	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Tumor or Growth on head or neck	❑ Yes	❑ No
Ulcer	❑ Yes	❑ No
Venereal Disease	❑ Yes	❑ No
Weight Loss, unexplained	❑ Yes	❑ No

Women:

Taking birth control pills ❑ Yes ❑ No Are you pregnant? ❑ Yes ❑ No Due Date _____ Are you nursing ? ❑ Yes ❑ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____ Phone ( ) _____

Allergies

❑ Aspirin
❑ Barbiturates (Sleeping Pills)
❑ Codeine
❑ Iodine
❑ Latex
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other _____
❑ None

Patient Signature _____ Date _____