Dr. Shelby C. Byler
1530 South 70th, Suite 104
Lincoln, NE 68506

Date_____

Name_____
First Middle Last

SS#_____ Date of Birth_____ Age_____ Sex_____

Address_____
(City/ State/ Zip)

Phone Numbers: Home_____ Work_____ Cell_____

MEDICAL HISTORY (CIRCLE CORRECT ANSWER)

YES NO Are you under the care of a physician?
If yes, for what?_____

Name and address of physician_____

YES NO Have you been hospitalized or had a serious illness within the past five (5) years?
If yes, be specific_____

YES NO Are you now taking any drugs or medicines (e.g. cortisone, aspirin, anti-depressants, vitamins, anticoagulant, osteoporosis medication, etc.)
If yes, be specific_____

DO YOU HAVE OR HAVE YOU HAD:

YES NO Rheumatic fever or rheumatic heart disease
YES NO Heart trouble or Murmur
YES NO Heart surgery (bypass, valve)
YES NO A Pacemaker
YES NO A Stent
YES NO High blood pressure
YES NO Chest pains
YES NO Breathing problems (i.e. shortness of breath)
YES NO Asthma or emphysema
YES NO Hay fever
YES NO Sinus infection
YES NO Anemia
YES NO Bleeding disorders
YES NO Swelling of feet or ankles
YES NO Stomach or digestive trouble
YES NO Hepatitis, jaundice or liver problems
YES NO Aids, ARC, HIV, Anti- HIV
YES NO Allergies or drug reactions (e.g. hives, skin rash, breathing problems)
YES NO Tuberculosis (TB)
YES NO Diabetes
YES NO Kidney or urinary problems (i.e. frequent urination, etc.)
YES NO Prosthetic Surgery (hip-knee replacement etc.)
YES NO Cancer or tumor
YES NO Radiation treatment (e.g. head and neck or other) for cancer or tumor
YES NO Convulsions, seizures, epilepsy, or fainting
YES NO Arthritis
YES NO Sexually transmitted diseases
YES NO Endocrine disturbances (i.e. thyroid disease, etc.)
YES NO Drug or Alcohol abuse problems
YES NO Psychological or emotional problems
YES NO Frequent Headaches
YES NO Do you have any disease, condition, or problem not listed above that I should know about?
If so, explain_____

HAVE YOU EVER HAD AN UNDESIRABLE REACTION TO:

YES NO Local anesthetics (e.g. Novocaine, etc.)?
YES NO Penicillin
YES NO Other antibiotics
YES NO Latex
YES NO Other drugs or medicines? (e.g. aspirin, codeine, etc.)
YES NO Have you had any serious trouble associated with any previous dental treatment, oral surgery, or tooth extractions?
If so, explain_____

FEMALES:

YES NO Are you pregnant?
YES NO Are you taking birth control pills?
YES NO Are you in or have you been through menopause?

DENTAL HISTORY:

YES NO Are you having discomfort at this time?
Explain_____
How long since you have been to a dentist?_____
What was done then?_____
YES NO Were x-rays taken?
YES NO Are any of your teeth sensitive to any of the following? Heat, cold, sweets?
YES NO Have you ever had your teeth straightened?
YES NO Have you ever had a gum infection?
YES NO Previous periodontal treatment? (Gum treatment)
YES NO Do your gums bleed when you brush?
YES NO Do you have an unpleasant taste in your mouth?
YES NO Do you have bad breath?
YES NO Do you smoke?
YES NO Do you grind or clench your teeth?
YES NO Do you eat between meals? If yes, what_____
How often do you brush your teeth?_____ When_____
What type of brush do you use? Electric_____ Manual_____
What type of bristles are in your brush? Hard_____Med. _____ Soft_____
Oral habits? (E.g. nail biting, pencil chewing)_____
YES NO Additional cleaning aids? Floss, Stimulator, Irrigator, Disclosing tablets_____
Other devices_____What do you think of your teeth?_____

How were you referred to our office?_____

MEDICAL HISTORY REVIEWED:

Date	Initials	Date	Initials	Date	Initials	Date	Initials