BERKSHIRE DENTAL ASSOCIATES, LTD

1260 Broadcasting Road, Suite 100
Wyomissing, PA 19610
610-376-3210

Robert J. Shuttlesworth, D.D.S., M.S.
Patti G. Stokes, D.D.S.

DENTAL HISTORY

Name of Previous Dentist_____ Date of last Exam_____

Previous Dentist's Location_____ Date of last Cleaning_____

Reason for today's visit_____ Date of last dental X-rays_____

How often do you floss? _____ How often do you brush?_____

Please check (☐) "yes" or "no" to indicate if you have/had any of the following:

Bad breath	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth of broken fillings	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Clicking of popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores of growths in mouth	☐ Yes	☐ No

Medical History

Physician's Name_____ Date of last visit_____

Phone (____)_____ Pharmacy_____ Phone (____)_____

Please check (☐) "yes" or "no" to indicate if you have/had any of the following:

High Blood Pressure	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Chest Pains	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Cardiac Pacemaker	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	MVP	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Hay Fever/Allergies	☐ Yes	☐ No
Fainting/Seizures	☐ Yes	☐ No	Angina	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Frequently Tired	☐ Yes	☐ No	Radiation	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Epilepsy/Convulsions	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Joint Rplcmnt/Implant	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Hepatitis/Jaundice	☐ Yes	☐ No	Heart Troubles	☐ Yes	☐ No
AIDS or HIV Infection	☐ Yes	☐ No	Sexually Trans. Disease	☐ Yes	☐ No	Respiratory Problems	☐ Yes	☐ No
Thyroid Problem	☐ Yes	☐ No	Stomach Troubles/Ulcers	☐ Yes	☐ No	OTHER_____	☐ Yes	☐ No

Are you allergic to any of the following?

Aspirin	☐ Yes	☐ No	Metals(i.e.gold)	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No
Local Anesthesia	☐ Yes	☐ No	Sulfa	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No	Iodine	☐ Yes	☐ No
Latex	☐ Yes	☐ No	Codeine	☐ Yes	☐ No
OTHER_____	☐ Yes	☐ No			

Have you ever taken any of these medications?

Blood Thinners	☐ Yes	☐ No
Coumadin	☐ Yes	☐ No
Warfarin	☐ Yes	☐ No
Levoxyl	☐ Yes	☐ No
Synthroid	☐ Yes	☐ No

Please list all medications now taking:_____