Personal Pathological History

Patient Name:_____ Date:___/___/___

Cardiovascular : Yes___ No___
Who / Details:_____
_____

Metabolic: Yes___ No___
Who / Details:_____
_____

Hematology : Yes___ No___
Who / Details:_____
_____

Cancer: Yes___ No___
Who / Details:_____
_____

Neurological: Yes___ No___
Who / Details:_____
_____

Respiratory: Yes___ No___
Who / Details:_____
_____

Fractures: Yes___ No___
Specify:_____
Date:_____
Complications:_____

Surgeries: Yes___ No___
Type:_____
Date:_____
Complications:_____

Hospital:_____

Transfusions: Yes___ No___
Reason:_____
Date:_____

Pain chewing: Yes___ No___
Tooth sensivity :
Cold : ___ Heat : ___ Sweet:___

How often do you brush your teeth daily:
_____

Bleeding gums when brushing:
Never:___ Occasionally:___ Always:___

Pain when brushing:
Yes___ No___

Prescence of canker sores or mouth ulcers:
Yes___ No___

Loss of teeth:
Yes___ No___

Have received dental anesthesia:
Yes___ No___

Dental Extractions: Yes ___ No ___
Complications:_____
Coagulation:_____
Institution:_____
Attending Dentist:_____

Dental Trauma:
Type:_____
Date:_____
Institution:_____
Attending Dentist:_____

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