Oscar Castañeda D.D.S., M.S. PA
21434 Provincial Blvd
Katy, TX 77450

Dental History Form

As a patient at our Dental Office it is your responsibility to provide us with any prescriptions that you are currently taking and make us aware of any dental or medical complications you have encountered. Failure to provide this information can lead to serious complications with your dental treatment. **Please Initial**_________

Current Medications (prescription, over the counter and herbal)

Are you taking any blood thinners? Yes / No ________________________

Are you taking any bioposphates? Yes / No ________________________

Medication	Dosage	Medication	Dosage

Name of Previous Dentist: ________________________ **Date of Last Exam** ____________

Please check all that apply

	Yes	No		Yes	No
1. Do your gums bleed?			9. Do you clench or grind your teeth?		
2 .Are your teeth sensitive to hot or cold?			10. Do you bite your lips or cheeks frequently?		
3. Are you teeth sensitive to sweet or our foods?			11. Have you ever had any difficulty extractions in the past?		
4. Do you feel pain to any of your teeth?			12. Have you ever had prolonged bleeding following extractions?		
5. Do you have any sores or lumps in or near your mouth?			13. Have you had any orthodontic treatment?		
6. Have you had any head, neck or jaw injuries? If yes explain:			14. Do you wear dentures or partials? If Yes date of placement?		
7. Have you ever experience any of the following Problems in your jaw?			15. Any congenitally missing teeth? If yes How many?		
Clicking			16. Have you had any oral surgery?		
Pain(joint, ear , side of face)			17. Any loose teeth?		
Difficulty opening or closing			18. Mouth odors / bad taste?		
Difficulty in chewing			19. Dry mouth / Excessive thirst?		
8. Do you have frequent headaches?			20. Do you use fluoridate		