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DENTAL HEALTH HISTORY

(Confidential)

Patient Name____ Birthdate________________________
(Last) (First) (M.I)

DENTAL HISTORY

Reason for today's visit____

Former Dentist____

Date of last dental visit ________________________________Date of last x-rays_____________________

Check (✓) if you have problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Tooth Color
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____________________How often do you brush?________________________

MEDICAL HISTORY

Physician's Name ___________________________________ Date of last visit_________________________

Have you had any serious illnesses or operations? ___________If yes, describe_____________________
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(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control pills? ☐ Yes ☐ No

Check (✓) if you have **or** have had any of the following:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cold Sores
- ☐ Convulsions
- ☐ Cortisone Treatment
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Disease

Describe_____________

- ☐ Heart Pacemaker
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in jaw joints
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Other ___________________________________
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers

MEDICATIONS

Please list any medications you are currently taking____
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ALLERGIES

- ☐ Acrylic
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine (Sleeping Pills)
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other ___________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Date _____________________________________ Signature____________________________________