DENTAL HEALTH HISTORY

(Confidential)

Today's Date:_____

Patient Name: _____ Birth Date: _____

Last First Initial

DENTAL HISTORY

Reason for Today's Visit : _____

Former Dentist : _____

Address : _____

Date of last dental care : _____ Date of last dental X-rays : _____

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

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ 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 : _____

Have you ever had a blood transfusion? ◯ Yes ◯ No If yes, give approximate dates _____

(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
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems

  Describe _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS	ALLERGIES
List medications you are currently taking: _____ _____ Pharmacy Name : _____ Phone : _____	☐ Aspirin ☐ Penicillin ☐ Barbiturates (Sleeping pills) ☐ Sulfa ☐ Codeine ☐ Other _____ ☐ Local Anesthetic ☐ Latex _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her Staff responsible for any errors or omissions that I may have made in the completion of this form.

Date : _____ Signature : _____