Dental History

Patient's Name:_____Date:_____

Reason for today's visit:_____Date of last dental visit:_____

Check if you have had problems with the following:

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

How often do you brush?_____Floss?_____Do you use any dental aides?_____

Medical History

Physician's Name:_____Date of last visit:_____

Are you under the care of a physician now?_____Do you smoke or use tobacco?_____

Are you **allergic to any medications, drugs, metal or latex?_____

Do you have, or have you had any of the following?

- ☐ AIDS/HIV Positive*
- ☐ Alzheimer's/Dementia*
- ☐ Anaphylaxis*
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint*
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood pressure(High/Low)*
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chemotherapy*
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder*
- ☐ Diabetes*
- ☐ Drug Addiction*
- ☐ Emphysema/COPD*
- ☐ Epilepsy/Seizures*
- ☐ Excessive Bleeding
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Headaches
- ☐ Heart Attack/Failure
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease*
- ☐ Hepatitis* _____
- ☐ Hives/Rash
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Care
- ☐ Radiation Treatments*
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Sinus Trouble/Allergies
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers

Have you ever had any serious illness not listed above?_____

List Current Medications(prescription or OTC:

_____

_____

_____

Women: Are you

- ☐ Pregnant(Weeks:_____)
- ☐ Taking Contraceptive
- ☐ Taking Hormones
- ☐ Nursing

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 health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature:_____Date:_____