DENTAL HEALTH HISTORY (Confidential)

Patient Name _____ Birthdate _____ Today's Date _____
Last First Initial

Reason for today's visit _____ Former Dentist/Address _____

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

Check if you have had problems with any of the following:

- ☐ Grinding Teeth
- ☐ Bleeding Gums
- ☐ Sores or Growths in Mouth
- ☐ Loose Teeth or Broken Fillings
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting
- ☐ Clicking or Popping Jaw
- ☐ Bad Breath
- ☐ Collection Between Teeth
- ☐ Periodontal Treatment

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you had any serious illness or operations? _____ If yes, describe _____

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

(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
- ☐ 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/Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

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

The approved 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 _____