

Your general health problems or medications could have an interference with the dentistry that you will receive
Thank you for answering the following questions

Patient _____

Date _____

DENTAL HISTORY

Purpose of initial vist? _____

	Yes	No		Yes	No
Are your teeth sensitive to hot or cold?	<input type="checkbox"/>	<input type="checkbox"/>	History of frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweets?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lip or cheek?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have periodontal disease?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had orthodontic work?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	History of prolonged bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any mouth sores or inflamed areas?	<input type="checkbox"/>	<input type="checkbox"/>	History of difficult extractions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	History of reaction the dental numbing medication?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced any of these jaw problems?	<input type="checkbox"/>	<input type="checkbox"/>	Do you floss routinely?	<input type="checkbox"/>	<input type="checkbox"/>
a) Clicking	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or chew?	<input type="checkbox"/>	<input type="checkbox"/>
b) Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
c) Difficulty opening or closing mouth	<input type="checkbox"/>	<input type="checkbox"/>			
d) Difficulty chewing	<input type="checkbox"/>	<input type="checkbox"/>			
e) Chew on one side of your mouth	<input type="checkbox"/>	<input type="checkbox"/>			

Name of previous dentist (optional) _____

Date of last full mouth x-ray (16 films or panoramic) _____

MEDICAL HISTORY

PHYSICIAN _____

DATE OF LAST EXAM _____

Have you been hospitalized or had surgeries? List _____

Have you had a serious accident involving your head or jaw? _____

Are you allergic to any medications or substances? Check below

Aspirin Penicillin Codeine Acrylic Metal Latex Other _____

Women (please check) Pregnant/Trying to get pregnant Nursing Taking birth control pills _____

Do you now have or have you ever had any of the following: Please check appropriate boxes

If yes to any of the starred conditions, please call prior to your appointment: premedication may be required

	Yes	No		Yes	No		Yes	No
Heart trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur or Defect*	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Steroid Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	HIV virus/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Intestine Disease	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement/Implant*	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Cancers	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy (cancer/leukemia)	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any other serious illness not checked above/Discuss _____

Please List any medications you take including non-prescription drugs: _____

To the best of my knowledge the above answers are correct. If I have any changes in my health status or medications, I shall inform the Dentist/ Staff

X _____ Date _____

Patient/Parent or Guardian