Dental History

Name _____

What is the reason for your visit today? _____ Are you having any dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental visit _____ Date of last x-rays _____

Check "YES" or "NO" if you have had problems with any of the following:

How often do you brush? _____ Floss? _____

❑ Y ❑ N Bad breath	❑ Y ❑ N Food collection between teeth	❑ Y ❑ N Periodontal treatment	❑ Y ❑ N Sensitivity to biting
❑ Y ❑ N Bleeding gums	❑ Y ❑ N Grinding or clenching of teeth	❑ Y ❑ N Sensitivity to cold	❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Clicking, popping, or jaw pain	❑ Y ❑ N Loose teeth or broken filling	❑ Y ❑ N Sensitivity to hot	❑ Y ❑ N Sores or growths in mouth

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Physician's Name _____ Phone _____

Date of last visit _____ Have you had a serious illnesses or operations? ❑ Y ❑ N Hospitalized? ❑ Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Are you using birth control? ❑ Y ❑ N What type: _____

Indicate which of the following you have had, or have at present. Check "YES" or "NO" for each item.

❑ Y ❑ N AIDS/HIV Positive	❑ Y ❑ N Contacts	❑ Y ❑ N Hepatitis A, B, or C	❑ Y ❑ N Respiratory disease
❑ Y ❑ N Anaphylaxis/Atopic (allergy prone)	❑ Y ❑ N Cortisone treatment	❑ Y ❑ N High blood pressure	❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Anemia	❑ Y ❑ N Cough, persistent	❑ Y ❑ N Kidney disease or malfunction	❑ Y ❑ N Sinus Trouble
❑ Y ❑ N Arthritis, Rheumatism	❑ Y ❑ N Cough up blood	❑ Y ❑ N Liver disease	❑ Y ❑ N Shortness of breath
❑ Y ❑ N Artificial heart valves	❑ Y ❑ N Diabetes	❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)	❑ Y ❑ N Stroke
❑ Y ❑ N Anything Artificial (joints, pins, screws, plates, implants, etc.)	❑ Y ❑ N Epilepsy or Seizures	❑ Y ❑ N Mitral valve prolapse	❑ Y ❑ N Surgical implant
❑ Y ❑ N Asthma	❑ Y ❑ N Fainting	❑ Y ❑ N Pacemaker/Heart surgery	❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Back problems	❑ Y ❑ N Food allergies	❑ Y ❑ N Psychiatric care	❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Blood Disease	❑ Y ❑ N Glaucoma	❑ Y ❑ N Rapid weight gain or loss	❑ Y ❑ N Tobacco habit
❑ Y ❑ N Blood Transfusion	❑ Y ❑ N Headaches	❑ Y ❑ N Radiation treatment	❑ Y ❑ N Tonsillitis
❑ Y ❑ N Cancer	❑ Y ❑ N Heart murmur	❑ Y ❑ N Remicade infusion or infusion treatments	❑ Y ❑ N Tuberculosis
❑ Y ❑ N Chemical dependency	❑ Y ❑ N Heart problems	Exp _____	❑ Y ❑ N Tumor
❑ Y ❑ N Chemotherapy	Describe _____		❑ Y ❑ N Venereal disease
❑ Y ❑ N Circulatory problems	❑ Y ❑ N Hemophilia/Abnormal bleeding		
	❑ Y ❑ N Herpes		

If yes to any of the above explain: _____

Is patient currently taking any medication? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Parent/Guardian Signature _____ Date _____

Dr. Signature _____ Date _____