DENTAL HISTORY

Patients Name: ____________________________
Reason for today's visit ____________________________
____
____
Former Dentist ____________________________
Reason for leaving ____________________________

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

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Tobacco products	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Headache/Neck Pain	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Any hospitalizations?	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Interested in Whitening	☐ Yes	☐ No
Happy with your smile:	☐ Yes	☐ No
Interest in straightening teeth	☐ Yes	☐ No

Reason ____________________________
How often do you brush? ______ Floss? ______

HEALTH HISTORY

Physician's Name: ____________________________ Last visit date: ____________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have ever had any of the following:

AIDS/HIV	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding abnormally, with Extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough/Persistent	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or Dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems/Surgery	☐ Yes	☐ No
Hepatitis Type________	☐ Yes	☐ No
Herpes/Fever Blisters	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Bone Density Medicine	☐ Yes	☐ No
Weight Loss, Unexplained	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet/Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or Growth on Head or Neck	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due Date: ____________________ Are You Nursing? ☐ Yes ☐ No

Taking Birth Control Pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking, Prescription or Non-Prescription

____
____
____

Pre-Med Needed: ☐ Yes ☐ No

ALLERGIES

- ☐ Aspirin
- ☐ Valium
- ☐ Codeine
- ☐ Tetracycline
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Erythromycin
- ☐ Other ____________
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SIGNED: ____________________________ *DATE:* ____________________