

DENTAL HEALTH HISTORY

(Confidential)

Patient Name: _____ Birthdate _____

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking/Popping Jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity when Biting |
| <input type="checkbox"/> Food Collection between teeth | <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Sores/Growths in Mouth |

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 dates _____

Women - Are you pregnant? ___Yes ___ No Nursing? ___Yes ___ No Birth Control Pills ___Yes ___ No

Check if you have or have had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nerve Problems | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems, Describe _____ | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophillia | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> High Blood Pressure | | |
| | <input type="checkbox"/> HIV Positive | | |

MEDICATIONS

Please list medications you are currently taking: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

ALLERGIES

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Penicillin | |

SIGNATURE

The above 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 error or omissions that I may have made in the completion of this form.

Patient Signature

Date