Dental History

Reason for today's visit?_____ Are you on well water? **YES or NO**

Former Dentist _____Date of last dental visit? ____/____/____

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

Are you happy with your smile? **YES or NO** If no, please explain _____

Do you have sensitivity in your mouth? **YES or NO** If yes, please explain _____

Have you had any of the following? ☐ Orthodontic Treatment ☐ Denture/Partial ☐Gum treatment ☐Night Guard

Medical History

Physician's Name _____ Phone Number _____

Are you currently under physician's care? **YES or NO** If yes, please explain _____

Have you had any hospitalizations, operations or major surgeries? **YES or NO** If yes, please explain _____

_____

Do you require antibiotic prophylaxis for dental treatment due to any medical condition/surgery? **YES or NO**

Are you currently taking or have you ever taken Bisphosphonates **YES or NO**

Women: Are you pregnant? **YES or NO** If yes, due date ___/___/___ If no, are you taking oral contraceptive? **Yes or NO**

Medications currently taking: List any medications you are taking and correlating diagnosis

_____

_____

Medications for emergency? Have you ever carried/do you currently carry any medication in case of an emergency?

☐ Nitroglycerin ☐ Glucose ☐ Insulin ☐Inhaler ☐Epi Pen

Allergies: Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Sulfa

Any other allergies? _____

Habits

☐ Use tobacco Type? _____ How long? _____How much per day?_____

☐ Use alcohol? How much per WEEK? _____ ☐ Use Drugs _____

Do you have or have you had any of the following?

☐ AIDS/HIV
☐ Artificial Heart Valves
☐ Cancer
☐ Congenital Heart Disease
☐ Emphysema
☐ Diabetes
☐ Glaucoma
☐ Heart Pacemaker
☐ Behavioral/Social Disorders
☐ Kidney Disease/Dialysis
☐ Lung Disease
☐ Psychological Disorders
☐ Renal Dialysis
☐ Shingles
☐ Stroke
☐ Swollen Neck/Glands
☐ Tuberculosis

☐ Anemia
☐ Artificial Joints
☐ Back Problems
☐ Chemotherapy/Radiation
☐ Cortisone Treatments
☐ Epilepsy or Seizures
☐ Heart Attack, Surgery, Disease
☐ Hepatitis Type _____
☐ High Blood Pressure
☐ Liver Disease
☐ Measles/Measles Vaccine
☐ Rheumatic Fever
☐ Sickle Cell Disease
☐ Stomach Disease
☐ Thyroid/Parathyroid Disease

☐ Arthritis, Rheumatism
☐ Asthma
☐ Abnormal Bleeding
☐ Cold Sores/Fever Blisters
☐ Dental Anxiety
☐ Fainting or Dizziness
☐ Heart Murmur/MVP
☐ Headaches
☐ High Cholesterol
☐Infective Endocarditis
☐ Low Blood Pressure
☐ Respiratory Disease
☐ Scarlet Fever
☐ Sinus Trouble
☐ Intestinal Disease
☐ Tonsillitis
☐ Venereal Disease

Any conditions not listed above? _____ _____

Signature of patient or parent: _____