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
_____
_____

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
☐ Herpes
☐ Kidney Disease
☐ Lung Disease
☐ Psychiatric Care
☐ Renal Dialysis
☐ Shingles
☐ Stroke
☐ Swollen Neck/Glands
☐ Tuberculosis

☐ Anemia
☐ Artificial Joints
☐ Back Problems
☐ Chemotherapy
☐ Cortisone Treatments
☐ Epilepsy or Seizures
☐ Heart Attack, Surgery, Disease
☐ Hepatitis Type _____
☐ High Blood Pressure
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Sickle Cell Disease
☐ Stomach Disease
☐ Thyroid Disease
☐ Tumors/Growths

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

Any conditions not listed above? _____ _____

Signature of patient or parent: _____