DENTAL HISTORY

Patient's Name: ____________________

Former Dentist: ____________________ Phone: ( ) - __________

Address: ____________________ City: __________ State: ____ Zip: ______

Date of last dental care: __________ Date of last x-rays: __________

What would you like us to do today? : __________ Are you in dental discomfort today? : ☐ Yes, ☐ No

Check if you have had problems with any of the following:

☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food collecting between teeth
☐ Grinding or clenching teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Reaction to anesthesia
☐ Sores or growths in mouth
☐ Sensitivity to hot
☐ Sensitivity to cold
☐ Sensitivity to sweets
☐ Sensitivity to biting

How often do you brush ? __________ Floss ? __________

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

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure ? ☐ Yes, ☐ No

Other information about your dental health or previous treatment: __________

MEDICAL HISTORY

Physician's Name: ____________________ Phone: ( ) - __________

Date of last visit: __________ Have you had any serious illnesses or operations ? ☐ Yes, ☐ No

If yes describe: ____________________

Are you currently under a physician's care ? ☐ Yes, ☐ No, if yes, describe: __________

Women: Are you pregnant? ☐ Yes, ☐ No, Nursing? ☐ Yes, ☐ No, Taking birth control pills? ☐ Yes, ☐ No

Check if you have had any of the following:

☐ AIDS/HIV Positive
☐ Anaphylaxis
☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial heart valves
☐ Artificial joints
☐ Asthma
☐ Blood disease
☐ Cancer
☐ Chemical dependency
☐ Chemotherapy
☐ Circulatory problems
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart murmur
☐ Heart problems describe: __________
☐ Hemophilia / Abnormal bleeding
☐ Hepatitis
☐ Herpes (cold sores)
☐ High blood pressure
☐ Jaw pain
☐ Liver disease
☐ Material allergies: latex, metal, etc.
☐ Mitral valve prolapse
☐ Nervous problems
☐ Pacemaker/Heart surgery
☐ Psychiatric care
☐ Radiation treatment
☐ Respiratory disease
☐ Rheumatic/ Scarlet Fever
☐ Shortness of breath
☐ Stroke
☐ Surgical implant
☐ Thyroid disease or malfunction
☐ Tobacco habit
☐ Tuberculosis
☐ Venereal disease

List medications you are currently taking, if any: ____________________

____

List drug allergies, if any: ____________________