DENTAL HISTORY

PATIENT NAME ____ Birth Date ____

What is the reason for your visit today?____
Former Dentist? City & State?____
Date of last dental cleaning?____ Date of last X-Rays:____

Please check any of the following that apply:

O Bad Breath
O Bleeding Gums
O Blisters on lips/mouth
O Burning sensation on tongue
O Chew on one side of mouth
O Clicking or popping jaw
O Dry mouth
O Fingernail biting
O Foreign objects
O Grinding/Clenching teeth
O Gums swollen or tender
O Jaw pain or tiredness
O Lip or cheek biting
O Loose teeth
O Broken fillings
O Mouth breathing
O Mouth pain, brushing
O Orthodontic Treatment
O Pain in/around ear
O Periodontal treatment
O Sensitivity to cold
O Sensitivity to hot
O Sensitivity to sweets
O Sensitivity to chewing
O Sores or growths in mouth
O Food collection between teeth
O Pain in jaw joints

How often to you floss?____ How often to you brush?____
Do you still have your wisdom teeth? If yes, why?
____
Do you require pre-medication before dental treatment?
____
Are you happy with your smile?__________ If not, what would you like to change?____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If yes, please explain:____
Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain:____
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain:____
Are you taking any over the counter or prescription medications? O Yes O No If yes, please explain:____
Do you take, or have you taken, Phen-Fen or Redux? O Yes O No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? O Yes O No
Are you on a special diet? O Yes O No
Do you use tobacco? O Yes O No
Do you use controlled substances? O Yes O No

WOMEN: Are you
Pregnant/ Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?

O Aspirin
O Penicillin
O Codeine
O Local Anesthetics
O Acrylic
O Metal
O Latex
O Sulfa drugs
O Other If yes, please explain:____

Do you have, or have you had, any of the following? Check ALL that may apply to you.

O ADD/ADHD
O Diabetes
O Hives or Rash
O Sinus Trouble
O AIDS/HIV Positive
O Drug Addiction
O Hypoglycemia
O Spina Bifida
O Anaphylaxis
O Emphysema
O Irregular Heartbeat
O Stomach Disease
O Anemia
O Epilepsy or Seizures
O Kidney Problems
O Stroke
O Angina
O Excessive Bleeding
O Leukemia
O Swelling of Limbs
O Arthritis/Gout
O Excessive Thirst
O Liver Disease
O Thyroid Disease
O Artificial Heart Valve
O Fainting Spells/Dizziness
O Low Blood Pressure
O Tonsillitis
O Artificial Joints
O Frequent Headaches
O Lung Disease
O Tuberculosis
O Asthma
O Hay Fever
O Mitral Valve Prolapse
O Tumors/Growths
O Autism
O Heart Attack/Failure
O Osteoporosis
O Ulcers
O Blood Disease
O Heart Murmur
O Parathyroid Disease
O Blood Transfusion
O Heart Pacemaker
O Psychiatric Illness/Disorder
O Bruise Easily
O Heart Surgery
O RadiationTreatment
O Cancer
O Hemophilia
O Recent Weight Loss
O Chemotherapy
O Hepatitis A
O Rheumatic Fever
O Chest Pains
O Hepatitis B or C
O Rheumatism
O Cold Sores/Fever Blisters
O Herpes
O Scarlet Fever
O Congenital Heart Disorder
O High Blood Pressure
O Shingles
O Cortisone Medicine
O High Cholesterol
O Sickle Cell Disease

Have you ever had any serious illness not listed above? O Yes O No
If yes, please explain:____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________________ DATE ______________________