DENTAL HISTORY

Reason for today's visit _____ Former Dentist _____

Date of last visit _____ Date of last dental x-rays _____

Check if you have had any of the following:

- ❑ Bad breath, frequent
- ❑ Bleeding gums
- ❑ Clicking and popping jaw
- ❑ Food collection between teeth
- ❑ Loose teeth
- ❑ Broken teeth
- ❑ Broken fillings
- ❑ Periodontal treatment
- ❑ Teeth sensitive to cold
- ❑ Teeth sensitive to heat
- ❑ Teeth sensitive to sweets
- ❑ Sores or growths in mouth
- ❑ Unusual reaction to dental anesthetic
- ❑ Orthodontic treatment
- ❑ Injury to face or jaws
- ❑ Other dental problems

_____

_____

Do you use tobacco? Yes No

Are you alcohol or drug dependent? Yes No

MEDICAL HISTORY

Physician's name _____ Approximate Date of last visit _____

Have you had any serious illnesses or operations? Yes ☐ No ☐ If yes, when? _____

What? _____

(**Women only**) Are you pregnant? Yes No; Nursing? Yes No Taking birth control pills? Yes No

Check if you have had any of the following

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches, Severe
- ❑ Heart Murmur
- ❑ Heart Problems Describe_____

_____

- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Latex Allergy
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Seizures
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling Feet/Ankles
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Other_____

_____

_____

Pulse_____

Blood Pressure_____

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

_____

_____

_____

Allergies to medications:

- ❑ Penicillin
- ❑ Codeine
- ❑ Aspirin
- ❑ Sulfa Drugs
- ❑ Other_____

_____

SIGNATURE

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment

_____ _____

Signature of Patient or Parent Date