DENTAL HISTORY

Reason for today's visit: _____ Date of last dental visit: _____

Former dentist: _____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No
Bad breath	❑	❑
Blisters on lips or mouth	❑	❑
Burning sensation on tongue	❑	❑
Chew on one side of mouth	❑	❑
Cigarette, pipe, or cigar smoking	❑	❑
Smokeless tobacco	❑	❑
Dry mouth	❑	❑
Food collection between teeth	❑	❑
Clench or grind teeth	❑	❑
Growths or sore spots in your mouth	❑	❑
Gums swollen, tender or bleeding	❑	❑

	Yes	No
Head, neck, jaw pain or aches	❑	❑
Lip or check biting	❑	❑
Loose tooth or broken fillings	❑	❑
Mouth breathing	❑	❑
Orthodontic treatment	❑	❑
Nitrous Oxide	❑	❑
Periodontal treatment	❑	❑
Sensitivity to pressure or implants (cold, heat, sweats)	❑	❑

How often do you floss?: _____

How often do you brush?: _____

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? _____

❑ Yes ❑ No

If Yes, please explain: _____

_____

_____

Have you ever had trouble from previous dental care? ❑ Yes ❑ No

If Yes, please explain: _____

_____

MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____

Physician's address: _____ Blood Pressure: _____

Have you had any serious illnesses or operations Yes ❑ No ❑ If Yes, please describe: _____

Have you ever had a blood transfusion Yes ❑ No ❑ If Yes, give approximate dates: _____

(Women) Are you pregnant? Yes ❑ No ❑ Due date: _____ Nursing? Yes ❑ No ❑ Taking birth control pills? Yes ❑ No ❑

Are you allergic to any of the following:

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic
❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Local Anesthetics

Other allergies: _____ If Yes, please describe _____

Do you use controlled substances? Yes ❑ No ❑ If Yes, please describe _____

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

AIDS/HIV Positive	❑Yes	❑No	Cortisone Medicine	❑Yes	❑No	Hemophilia	❑Yes	❑No	Radiation Treatments	❑Yes	❑No
Alzheimer's Disease	❑Yes	❑No	Diabetes	❑Yes	❑No	Hepatitis A	❑Yes	❑No	Recent Weight Loss	❑Yes	❑No
Anaphylaxis	❑Yes	❑No	Drug Addiction	❑Yes	❑No	Hepatitis B or C	❑Yes	❑No	Renal Dialysis	❑Yes	❑No
Anemia	❑Yes	❑No	Easily Winded	❑Yes	❑No	Herpes	❑Yes	❑No	Rheumatic Fever	❑Yes	❑No
Angina	❑Yes	❑No	Emphysema	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Rheumatism	❑Yes	❑No
Arthritis/Gout	❑Yes	❑No	Epilepsy or Seizures	❑Yes	❑No	High Cholesterol	❑Yes	❑No	Scarlet Fever	❑Yes	❑No
Artificial Heart Valve	❑Yes	❑No	Excessive Bleeding	❑Yes	❑No	Hives or Rash	❑Yes	❑No	Shingles	❑Yes	❑No
Artificial Joint	❑Yes	❑No	Excessive Thirst	❑Yes	❑No	Hypoglycemia	❑Yes	❑No	Sickle Cell Disease	❑Yes	❑No
Asthma	❑Yes	❑No	Fainting Spells/Dizziness	❑Yes	❑No	Irregular Heartbeat	❑Yes	❑No	Sinus Trouble	❑Yes	❑No
Blood Disease	❑Yes	❑No	Frequent Cough	❑Yes	❑No	Kidney Problems	❑Yes	❑No	Spina Bifida	❑Yes	❑No
Blood Transfusion	❑Yes	❑No	Frequent Diarrhea	❑Yes	❑No	Leukemia	❑Yes	❑No	Stomach/Intestinal Disease	❑Yes	❑No
Breathing Problems	❑Yes	❑No	Frequent Headaches	❑Yes	❑No	Liver Disease	❑Yes	❑No	Stroke	❑Yes	❑No
Bruise Easily	❑Yes	❑No	Genital Herpes	❑Yes	❑No	Low Blood Pressure	❑Yes	❑No	Swelling of Limbs	❑Yes	❑No
Cancer	❑Yes	❑No	Glaucoma	❑Yes	❑No	Lung Disease	❑Yes	❑No	Thyroid Disease	❑Yes	❑No
Chemotherapy	❑Yes	❑No	Hay Fever	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No	Tonsillitis	❑Yes	❑No
Chest Pains	❑Yes	❑No	Heart Attack/Failure	❑Yes	❑No	Osteoporosis	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Cold Sores/Fever Blisters	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Pain in Jaw Joints	❑Yes	❑No	Tumors or Growths	❑Yes	❑No
Congenital Heart Disorder	❑Yes	❑No	Heart Pacemaker	❑Yes	❑No	Parathyroid Disease	❑Yes	❑No	Ulcers	❑Yes	❑No
Convulsions	❑Yes	❑No	Heart Trouble/Disease	❑Yes	❑No	Psychiatric Care	❑Yes	❑No	Venereal Disease	❑Yes	❑No
									Yellow Jaundice	❑Yes	❑No

Have you ever had any serious illness not listed? ❑Yes ❑No If Yes, please explain _____

Medications!

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:

X_____ Date: _____