Dental History

Patient Name ____

Reason for Today's Visit ______________________ Date of Last Dental Care ____/____/____

Former Dentist ______________________ Date of Last Dental X-rays____/____/____

Are you happy with your smile? ☐ Yes ☐ No Did you have Orthodontic treatment? ☐ Yes ☐ No

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

☐ Bad breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Difficulty chewing
☐ Difficult extractions
☐ Food collection between the teeth
☐ Grinding or clenching teeth
☐ Ill-fitting dentures
☐ Loose teeth or broken fillings
☐ Missing teeth
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in your mouth

How often do you floss? ______________________ How often do you brush? ______________________

Medical History

Physician's Name______________________________________ Date of Last Visit ______________

Are you taking or scheduled to begin taking Bisphosphonates for the treatment of osteoporosis, Paget's disease or complications from cancer? (e.g. Actonel, Aredia, Boniva, Fosamax, Zometa) ☐ Yes ☐ No

Have you any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe ______________________________

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, give approximate dates ______________________

Do you wear contact lenses? ☐ Yes ☐ No

Have you ever taken Fen-phen/Redux? ☐ Yes ☐ No

(Women)

Are you pregnant? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

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

☐ Anemia
☐ Angina or Chest Pain
☐ Arthritis, Rheumatism
☐ Artificial Heart Valve
☐ Artificial Joints, Pins, etc.
☐ Asthma
☐ Auto Immune Disease
☐ Back Problems
☐ Bleeding Abnormality
☐ Blood Disease
☐ Cancer
☐ Controlled Substance Use
☐ Chemotherapy
☐ Chronic Pain
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Cortisone Treatments
☐ Cough Persistent or Bloody
☐ Diabetes (Type I or II)
☐ Eating Disorder
☐ Epilepsy or Seizures
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Heart Transplant
☐ Hemophilia
☐ Hepatitis, Jaundice, Liver Disease
☐ High Blood Pressure
☐ HIV.AIDS
☐ Infective Endocarditis
☐ Jaw Pain
☐ Kidney Disease
☐ Low Blood Sugar
☐ Mental Health Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease (e.g. COPD)
☐ Rheumatic Fever
☐ Sexually Transmitted Diseases
☐ Shortness of Breath
☐ Sinus Trouble
☐ Skin Rash
☐ Sleep Disorders, Snoring
☐ Stroke
☐ Swelling of Feet or Ankles
☐ Systematic Lupus Erythematosus
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tuberculosis
☐ Ulcer or Gastrointestinal Disease
☐ Other______________
☐ Other______________

List medications you are currently taking and the correlating Diagnosis:

____
____
____
____
____

Allergies: (e.g. Latex, Drugs, Local Anesthesia, Antibiotics, other)

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____
____
____

X______________________________ ____________ ______________________

Signature of Patient, Parent, Guardian or Personal Representative | Date | Relationship to Patient

OFFICE USE ONLY:

______________________ ______________________ ____/____/____

Doctor's Name (Print) | Doctor's Signature | Date

REV 7.22.2016