Dental History

Reason for today's visit:_____
Former dentist:_____
City/State:_____
Date of last dental visit:_____
Date of last dental X-rays:_____

Please **circle** "yes" or "no" to indicate if you experience any of the following:

Bad breath	yes	no	Chew on side of mouth	yes	no	Loose teeth or broken fillings	yes no
Bleeding gums	yes	no	Cigarette, pipe, or cigar smoking	yes	no	Mouth breathing	yes no
Blisters on lips or mouth	yes	no	Clicking or popping jaw	yes	no	Mouth pain when brushing	yes no
Burning sensation on tongue	yes	no	Dry mouth	yes	no	Orthodontic treatment	yes no
			Fingernail biting	yes	no	Pain around ear	yes no
			Food collection between teeth	yes	no	Periodontal treatment (gum)	yes no
			Foreign objects	yes	no	Sensitivity to hot, cold, or sweets	yes no
			Grinding teeth	yes	no	Sensitivity biting/chewing	yes no
			Gums swollen or tender	yes	no	Sores or growth in your mouth	yes no
			Jaw pain or tiredness	yes	no	How often do you brush? _____	
			Lip or cheek biting	yes	no	How often do you floss? _____	

Health History

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of the 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 physicians' care now? □ Yes □ No If yes, please explain:_____
Have you ever been hospitalized or had a major operation? □ Yes □ No If yes, please explain:_____
Have you ever had a serious head or neck injury? □ Yes □ No If yes, please explain:_____
Are you taking any medications, pills, or drugs? □ Yes □ No If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux? □ Yes □ No
Have you taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphates? □ Yes □ No
Are you on a special diet? □ Yes □ No
Do you use tobacco? □ Yes □ No If yes, indicate type:_____ How much:_____
Do you use controlled substances? □ Yes □ No
Are you allergic to the following:
□ Aspirin □ Penicillin □ Codeine □ Local anesthetics □ Acrylic □ Metal □ Latex □ Sulfa drugs
□ Other If yes, please explain: _____

Women, Are you:
Pregnant/trying to get pregnant? □ Yes □ No Taking oral contraceptives? □ Yes □ No Nursing? □ Yes □ No Due Date: _____
Pharmacy Name:_____ Pharmacy #: (_____) _____-_____

Do you have, or have you had, any of the following? Please **circle** "yes" or "no"

AIDS/HIV Positive	yes	no	Emphysema	yes	no	Hypoglycemia	yes	no	Swelling of Limbs	yes	no
Alzheimer's Disease	yes	no	Epilepsy or Seizures	yes	no	Irregular Heartbeat	yes	no	Thyroid Disease	yes	no
Anaphylaxis	yes	no	Excessive Bleeding	yes	no	Kidney Problems	yes	no	Tonsillitis	yes	no
Anemia	yes	no	Excessive Thirst	yes	no	Leukemia	yes	no	Tuberculosis	yes	no
Angina	yes	no	Fainting	yes	no	Liver Disease	yes	no	Tumor or Growth	yes	no
Arthritis/Gout	yes	no	Spells/Dizziness	yes	no	Low Blood Pressure	yes	no	Ulcers	yes	no
Artificial Heart Valve	yes	no	Frequent Cough	yes	no	Lung Disease	yes	no	Venereal Disease	yes	no
Artificial Joint	yes	no	Frequent Diarrhea	yes	no	Mitral Valve Prolapse	yes	no	Yellow Jaundice	yes	no
Asthma	yes	no	Frequent Headaches	yes	no	Osteoporosis	yes	no			
Blood Disease	yes	no	Genital Herpes	yes	no	Pain in Jaw Joints	yes	no	Have you ever had a serious illness		
Blood Transfusion	yes	no	Glaucoma	yes	no	Parathyroid Disease	yes	no	not listed above?		
Breathing Problem	yes	no	Hay Fever	yes	no	Psychiatric Care	yes	no	If yes, please explain_____		
Bruise Easily	yes	no	Heart Attack/Failure	yes	no	Radiation Treatment	yes	no	_____		
Cancer	yes	no	Heart Murmur	yes	no	Recent Weight Loss	yes	no			
Chemotherapy	yes	no	Heart Pace Maker	yes	no	Renal Dialysis	yes	no	Do you require antibiotic premedi-		
Chest Pains	yes	no	Heart Trouble/Disease	yes	no	Rheumatism	yes	no	cation for dental visits?	yes	no
Cold Sores/Fever Blisters	yes	no	Hemophilia	yes	no	Scarlet Fever	yes	no			
Congenital Heart Disease	yes	no	Hepatitis A	yes	no	Shingles	yes	no	Comments:_____		
Convulsions	yes	no	Hepatitis B or C	yes	no	Sickle Cell Disease	yes	no	_____		
Cortisone Medicine	yes	no	Herpes	yes	no	Sinus Trouble	yes	no	_____		
Diabetes	yes	no	High Blood Pressure	yes	no	Spina Bifida	yes	no	_____		
Drug Addiction	yes	no	High Cholesterol	yes	no	Stomach/Intestinal Disease	yes	no	_____		
Easily Winded	yes	no	Hives or Rash	yes	no	Stroke	yes	no	_____		

_____
Signature of Patient Date