Dental History

Patients Name: ______________________________

Reason for Today's Visit :____Date of Last Dental Care:________________

Former Dentist :____Date of Last Dental X-Rays:______________

Check if you have had a history with any of the following:

__Bad Breath
__Bleeding Gums
__Clicking or popping jaw
__Dry Mouth
__Grinding Teeth
__Loose teeth
__Food collection between teeth
__Broken fillings and/or crowns
__Sores or growths in the mouth
__Periodontal Treatment
__Sensitivity to cold/hot/sweets (circle)

How often do you floss? ____________________________ How often do you brush? ____________________________

Do you have any missing teeth? ______________________ Are you interested in permanent replacements?_______

Are you unhappy with the appearance of your teeth?____

Is there anything you would like to change about your smile?____

Medical History

Physicians Name:____Date of last visit: ____________________

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 or nursing? __Yes __No Taking birth control pills? __Yes __No

Check if you have had any of the following:

__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
__Heart Murmur
__Heart Attack/Angina
__Hemophilia
__Hepatitis
__High Blood Pressure
__HIV/AIDS
__Jaw Pain
__Kidney Disease
__Liver Disease
__Mitral Valve Prolapse
__Pacemaker
__Radiation Treatment
__Respiratory Disease
__Rheumatic Fever
__Scarlet Fever
__Short breath
__Skin Rash
__Stroke
__Swelling of joints
__Thyroid Problems
__Tobacco Habit
__Tonsillitis
__Tuberculosis
__Ulcer
__Venereal Disease

Please list any medications you are currently taking: ____

Have you ever taken any of the group of drugs collectively known as "fen-phen?" (Ionimin, Adipex, Fastin, Podimin, and Redux)? __Yes __No

Have you ever taken any of the group of drugs collectively known as Bisphosphonates (Fosomax, Boniva, Actonel, etc)? __Yes __No
If "Yes", were they taken by or an oral route or an intravenous route?

Are you allergic to any of the following:
__Penicillin __Aspirin __Iodine __Sulfa __Metals __Latex __Other (please list):__________________________

Have you ever had an adverse reaction to local anesthetic? __Yes __No If yes, please describe:______________________

___________________________________ ___________________
Signature of patient, parent, guardian, or personal representative Date

____________________________________ __________________
Please print name Relationship to patient

____________________________________ __________________
Dr. Signature Date

Blood Pressure __________ Pulse ________ ASA I II III IV