Dental History

Reason for today's visit:_____

_____

Former Dentist:_____

Date of last dental visit_____

Date of last dental x-rays_____

Mark "Yes " or " No" to indicate if you presently have or previously had any of the following:

Bad breath	Yes❑	No❑
Bite your lips or cheeks regularly	Yes❑	No❑
Bleeding Gums	Yes❑	No❑
Blisters on lips or mouth	Yes❑	No❑
Chew on one side of mouth	Yes❑	No❑
Dry mouth	Yes❑	No❑
Food collection between teeth	Yes❑	No❑
Grinding teeth	Yes❑	No❑
Gums swollen or tender	Yes❑	No❑
Jaw pain or tiredness	Yes❑	No❑
Mouth breathing	Yes❑	No❑
Orthodontic treatment	Yes❑	No❑
Pain around ear	Yes❑	No❑
Periodontal (gum) treatment	Yes❑	No❑
Sensitivity to cold	Yes❑	No❑
Sensitivity to hot	Yes❑	No❑

Have you experienced:

Clicking or popping of the jaw?	Yes❑	No❑
Pain? (joint, ear, side of face)	Yes❑	No❑
Dificulty in opening or closing the mouth?	Yes❑	No❑

How often do you floss?_____

How often do you brush?_____

Do you require antibiotics before dental treatment?	Yes❑	No❑
Are you currently in pain?	Yes❑	No❑
Have you ever had a serious / difficult problem associated with any previous dental work?	Yes❑	No❑
Do you like your smile?	Yes❑	No❑
Do you feel nervous about having dental treatment?	Yes❑	No❑
Have you ever had a bad experience in a dental office?	Yes❑	No❑

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know?____

_____

Medical History

Your Physical health is:

❑Good ❑Fair ❑Poor

Are you currently under the care of a physician? Yes❑ No❑

Please explain: _____

_____

Are you taking any prescription/ over the counter drugs? Yes❑ No❑

Please list each one:

_____

_____

_____

_____

_____

_____

_____

Do you smoke or use tobacco in any other forms? Yes❑ No❑

For Women:

Are you taking birth control pills?	Yes❑	No❑
Are you Pregnant?	Yes❑	No❑
Are you Nursing?	Yes❑	No❑

Do you have or have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	Yes❑	No❑
Alcohol / Drug Abuse	Yes❑	No❑
Alzheimer's Disease	Yes❑	No❑
Anemia	Yes❑	No❑
Arthritis	Yes❑	No❑
Artificial Bones / Joints/Valves	Yes❑	No❑
Asthma	Yes❑	No❑
Blood Transfusion	Yes❑	No❑
Bruise Easily	Yes❑	No❑
Cancer / Chemotherapy	Yes❑	No❑
Colitis	Yes❑	No❑
Diabetes	Yes❑	No❑
Difficulty Breathing	Yes❑	No❑
Emphysema	Yes❑	No❑
Epilepsy	Yes❑	No❑
Fainting Spells	Yes❑	No❑
Frequent Headaches	Yes❑	No❑
Glaucoma	Yes❑	No❑
Hay Fever	Yes❑	No❑
Heart Problems	Yes❑	No❑
Heart Murmur	Yes❑	No❑
Hemophilia	Yes❑	No❑

Do you have or have you ever had any of the following diseases or medical problems?

Hepatitis	Yes❑	No❑
Herpes / Fever Blisters	Yes❑	No❑
High Blood Pressure	Yes❑	No❑
HIV+ / AIDS	Yes❑	No❑
Joint Replacement	Yes❑	No❑
Kidney Problems	Yes❑	No❑
Liver Disease	Yes❑	No❑
Low Blood Pressure	Yes❑	No❑
Mitral Valve Prolapse	Yes❑	No❑
Nervous/Anxious	Yes❑	No❑
Pacemaker	Yes❑	No❑
Psychiatric/Physiological Care	Yes❑	No❑
Radiation Treatment	Yes❑	No❑
Rheumatic / Scarlet Fever	Yes❑	No❑
Seizures	Yes❑	No❑
Sinus Problems	Yes❑	No❑
Stroke	Yes❑	No❑
Thyroid Problems	Yes❑	No❑
Tuberculosis (TB)	Yes❑	No❑
Tumors or Growths	Yes❑	No❑
Ulcers	Yes❑	No❑
Venereal Disease	Yes❑	No❑
Do you have or have you had any disease, condition or problem not listed above?	Yes❑	No❑

If yes please describe_____

_____

Have you been hospitalized for any reason? Yes❑ No❑

If yes please describe_____

_____

Are you allergic to any of the following?

Amoxicillin	Yes❑	No❑
Aspirin	Yes❑	No❑
Clindamycin	Yes❑	No❑
Codeine	Yes❑	No❑
Dental Anesthetics	Yes❑	No❑
Erythromycin	Yes❑	No❑
Latex	Yes❑	No❑
Metals	Yes❑	No❑
Penicillin	Yes❑	No❑
Sulfa	Yes❑	No❑
Tetracycline	Yes❑	No❑

Other _____

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. I will not hold my dentist or any member of his Dental Team responsible for errors or omissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature:_____ Date:_____

I certify that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient or Responsible Party Signature :_____ Date:_____