

Name \_\_\_\_\_ Date \_\_\_\_\_

## Dental History

Reason for Today's Visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

Address \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> 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 \_\_\_\_\_

Have you had any serious illnesses or operations? If yes, describe \_\_\_\_\_

Have you ever had osteoporosis drugs with or without chemotherapy? If yes, describe \_\_\_\_\_

(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:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough up Blood    | <input type="checkbox"/> HIV Positive            | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Jaw Pain                | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Nervous Problems        | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur      | <input type="checkbox"/> Osteoporosis Treatments | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems    | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemotherapy            | Describe _____                             | <input type="checkbox"/> Psychiatric Care        | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia        | <input type="checkbox"/> Radiation Treatment     | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Cortisone Treatments    | <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> Respiratory Disease     | <input type="checkbox"/> Venereal Disease           |

List all of the medications your are taking and all allergies you are aware of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Verification

I verify the medical history information provided above to be complete and accurate.

I understand that I am responsible for any errors or omissions as well as updating the dentist on any future changes in my medical history.

Signature \_\_\_\_\_ Date \_\_\_\_\_