

Dental Health History

Name: _____

Reason for today's visit _____

Former Dentist _____

Phone _____

Date of last dental exam _____

Date of last dental x-rays _____

Date of last cleaning _____

How often do you brush? _____

How often do you floss? _____

Do you feel pain anywhere? _____

Describe _____

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

Sensitivity to hot or cold Yes No
Sensitivity to sweet Yes No

Avoid one side of the mouth when chewing Yes No
Sensitivity when biting Yes No

Broken / cracked fillings Yes No
Food collection between teeth Yes No

Tobacco use Yes No

Gums swollen or tender Yes No
Gums bleed frequently Yes No

Blisters on lips or mouth Yes No
Sores or growths inside cheek / in the mouth Yes No

Bad breath Yes No
Burning sensation on tongue Yes No
Dry mouth Yes No

Accident involving jaw Yes No

Clicking or popping jaw Yes No
Frequent headaches Yes No
Grinding teeth Yes No
Jaw pain or tiredness Yes No
Pain around ear Yes No

Orthodontic treatment Yes No
Periodontal treatment Yes No

Medical Health History

Physician _____ Phone _____

Please list all current medications (include prescription, over-the-counter, herbal supplements) and reason for use:

Are you allergic to any of the following?

Aspirin Codeine Latex Penicillin Valium

Other: _____

Have you ever had any of the following conditions?

Artificial joint/valve Heart murmur Mitral valve prolapse Rheumatic fever

Women Only:

Do you use birth control medication? Yes No
Are you nursing? Yes No
Are you pregnant? (Due date: _____) Yes No

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

AIDS / HIV Yes No
Anemia Yes No
Arthritis or Back problems Yes No
Asthma or Respiratory problems Yes No
Blood transfusion (Date: _____) Yes No
Cancer Yes No
Cardiac pacemaker Yes No
Convulsions / Epilepsy / Seizures Yes No
Diabetes Yes No
Excessive bleeding with extractions / surgery Yes No
Heart problems Yes No
Hepatitis or Liver problems Yes No
High / Low blood pressure Yes No
Kidney problems Yes No
Phen-Phen treatment Yes No
Radiation or Chemotherapy treatment Yes No
Sexually transmitted disease Yes No
Stroke Yes No
Thyroid disorder Yes No
Tuberculosis Yes No

Other: _____

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health.

X

Responsible Party Signature

Date

X

Attending Dentist Signature

Date