DENTAL HISTORY

Reason for today's visit _____

Date of last dental care_____ Date of last dental x-rays_____

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

☐ Bad Breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food caught between teeth
☐ Unsatisfactory appearance of your teeth
☐ Grinding teeth
☐ Loose teeth/broken fillings
☐ Periodontal Treatment
☐ Sores/growths in mouth
☐ Sensitivity to hot/cold
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Fear of dental treatment

How often do you floss?_____ Brush?_____ Is there fluoride in your drinking water?_____

MEDICAL HISTORY

Physician's Name _____ **Phone Number** _____

Date of last visit _____

Yes	**No**	
☐	☐	Has there been any problem with your general health in the last year? (Illnesses, operations) If yes, describe _____
☐	☐	Are you under the care of a physician? If yes, what is the condition being treated? _____
☐	☐	Are you taking or have you taken any medicines, including nonprescription medicine? Prescribed _____ Over the counter or herbal preparations _____
☐	☐	Have you taken any diet drugs, such as Pondimin, Redux, or Phen-fen?
☐	☐	Have you ever taken any bisphosphonates such as Fosamax, Reclast, Zometa, Actonel or Boniva?
☐	☐	Are you alcohol and/or drug dependent? If so, have you received treatment?_____
☐	☐	Do you use tobacco (smoking, snuff, chew)?
☐	☐	Women, are you pregnant? _____ Nursing? _____ Taking birth control pills? _____
☐	☐	Have you had an orthopedic joint replacement? If so, when was this done? _____
☐	☐	Has a physician or previous dentist recommended that you take antibiotics before your dental treatment? If so, what antibiotic and dose? _____

Check if you have had any of the following:

□ Abnormal bleeding
□ AIDS or HIV positive
□ Anemia
□ Arthritis, rheumatism
□ Asthma, hay fever
□ Blood transfusion, date
□ Cancer/chemotherapy, radiation
□ Cardiovascular disease
If yes, specify:
____Angina
____Artificial heart valve
____Heart attack
____Heart murmur
____High blood pressure
____Mitral Valve prolapse
____Pacemaker
□ Diabetes
□ Dry mouth
□ Eating disorder _____
□ Epilepsy
□ Fainting spells or seizures
□ Fever Blister/Cold Sore
□ Gastric reflux
□ Glaucoma
□ Herpes lesions
□ Hepatitis □ A □B □C
□ Kidney problems
□ Liver Disease
□ Low blood pressure
□ Mental health disorder
If yes, _____
□ Osteoporosis
□ Persistent cough, cough up blood
□ Respiratory problems
____ Emphysema
____ Bronchitis
□ Rheumatic fever
□ Severe headaches, migraines
□ Severe or rapid weight loss
□ Sexually transmitted disease
□ Sinus trouble
□ Sleep disorder
□ Stroke
□ Thyroid problems
□ Tuberculosis
□ Ulcers

□ Do you have any disease, condition or problem not listed that we should know about? Please explain: _____
_____

Allergies: Are you allergic to or have you had a reaction to:

□ Local anesthetics
□ Penicillin or other antibiotics
□ Barbiturates, sedatives, or sleeping pills
□ Aspirin
□ Sulfa drugs
□ Codeine or other narcotics
□ Iodine
□ Latex
□ Other_____

To yes Responses, specify type of reaction _____

Signature of Patient/Legal Guardian _____ **Date** _____