HEALTH/ DENTAL HISTORY

Name_____ Date_____

How do you wish to be addressed _____ Date of Birth _____

Reason for today's visit _____

Former dentist_____ Reason for leaving _____

Date of last dental visit_____ Reason for last dental visit_____

How often do you brush? _____ How often do you floss? _____

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS OR CONCERNS? (Circle all correct responses)

Bad breath	Y N	Food collection between teeth	Y N	Sensitivity to cold	Y N
Bleeding gums	Y N	Grinding of teeth	Y N	Sensitivity to hot	Y N
Locking jaw	Y N	Loose teeth	Y N	Sensitivity to sweets	Y N
Pain in jaw joint	Y N	Broken fillings	Y N	Sensitivity to biting	Y N
Toothaches	Y N	Swollen gum or face	Y N	Broken tooth	Y N

Have you ever had gum surgery? Y N If yes, when? _____ Do you **Smoke/ Chew (circle one)?** **Y N**
Physician's Name _____Phone _____Date of last exam_____

Allergies to Medications:

Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐
Other_____

Are you being treated for a current medical condition? **Y N** *List condition*:_____
Have you had any serious illness or operations? **Y N** *Describe*:_____
List current medications you are taking:_____
Are you currently taking **Bone Density medications? Y N** (circle one) If yes, what? _____
Men: Currently taking any ED medications? **Y N** (circle one) If yes, what? _____
Women: Are you pregnant/ trying to get pregnant? **Y N** Taking oral contraceptives? **Y N** Nursing? **Y N**

Do you have, or have you had, any of the following?

AIDS/ HIV Positive	**Y**	**N**	Cortisone Medicine	**Y**	**N**	Hepatitis A	**Y**	**N**	Renal Dialysis	**Y**	**N**
Alzheimer's Disease	**Y**	**N**	Diabetes	**Y**	**N**	Hepatitis B or C	**Y**	**N**	Restless Leg Syndrome	**Y**	**N**
Anaphylaxis	**Y**	**N**	Drug Addiction	**Y**	**N**	Herpes	**Y**	**N**	Rheumatic Fever	**Y**	**N**
Anemia	**Y**	**N**	Easily Winded	**Y**	**N**	High Blood Pressure	**Y**	**N**	Rheumatism	**Y**	**N**
Angina	**Y**	**N**	Emphysema	**Y**	**N**	High Cholesterol	**Y**	**N**	Scarlet Fever	**Y**	**N**
Arthritis/Gout	**Y**	**N**	Epilepsy or Seizures	**Y**	**N**	Hives or Rash	**Y**	**N**	Shingles	**Y**	**N**
Artificial Heart Valve	**Y**	**N**	Excessive Bleeding	**Y**	**N**	Hypoglycemia	**Y**	**N**	Sickle Cell Disease	**Y**	**N**
Artificial Joint	**Y**	**N**	Excessive Thirst	**Y**	**N**	Irregular Heartbeat	**Y**	**N**	Sinus Trouble	**Y**	**N**
Asthma	**Y**	**N**	Fainting Spells/Dizziness	**Y**	**N**	Kidney Problems	**Y**	**N**	Sleep Apnea	**Y**	**N**
Back Problems	**Y**	**N**	Frequent Cough	**Y**	**N**	Leukemia	**Y**	**N**	Sleep Apnea Appliance	**Y**	**N**
Blood Disease	**Y**	**N**	Frequent Diarrhea	**Y**	**N**	Liver Disease	**Y**	**N**	Spina Bifida	**Y**	**N**
Blood Transfusion	**Y**	**N**	Frequent Headaches	**Y**	**N**	Low Blood Pressure	**Y**	**N**	Stomach/Intestinal Disease	**Y**	**N**
Breathing Problem	**Y**	**N**	Genital Herpes	**Y**	**N**	Lung Disease	**Y**	**N**	Stroke	**Y**	**N**
Bruise Easily	**Y**	**N**	Glaucoma	**Y**	**N**	Mitral Valve Prolapse	**Y**	**N**	Swelling of Limbs	**Y**	**N**
Cancer	**Y**	**N**	Hay Fever	**Y**	**N**	Osteoporosis	**Y**	**N**	Thyroid Disease	**Y**	**N**
Chemotherapy	**Y**	**N**	Heart Attack/Failure	**Y**	**N**	Neck Problems	**Y**	**N**	Tonsillitis	**Y**	**N**
Chest Pains	**Y**	**N**	Heart Murmur	**Y**	**N**	Pain in Jaw Joints	**Y**	**N**	Tuberculosis	**Y**	**N**
Cold Sores/Fever Blisters	**Y**	**N**	Heart Pacemaker	**Y**	**N**	Parathyroid Disease	**Y**	**N**	Tumors or Growths	**Y**	**N**
Congenital Heart Disorder	**Y**	**N**	Heart Trouble/Disease	**Y**	**N**	Psychiatric Care	**Y**	**N**	Ulcers	**Y**	**N**
Convulsions	**Y**	**N**	Hemophilia	**Y**	**N**	Radiation Treatments	**Y**	**N**	Venereal Disease	**Y**	**N**
						Recent Weight Loss	**Y**	**N**	Yellow Jaundice	**Y**	**N**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____DATE_____