

DENTAL & HEALTH HISTORY
(Confidential)

Name _____ Birthdate _____

Reason for Today's Visit _____

Date of last dental care _____ Date of last X-rays _____

Please 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/broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking/popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection
between teeth | <input type="checkbox"/> Sores or growths in mouth | <input type="checkbox"/> Sensitivity to cold |

Medical History:

Any serious illnesses or operations? If yes, describe _____

Ever had any blood transfusions? If yes, give approximate dates _____

Women - Are you pregnant? Nursing? Taking birth control pills?

Check if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> High Blood Pres | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Pro | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problem | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Heart problems -
describe _____ | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Circulatory problems | | <input type="checkbox"/> Other _____ | |

Medications:

List medications you are currently taking:

Pharmacy Name _____

Phone # _____

Allergies:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local anesthetic | |

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date

Signature