DENTAL HEALTH HISTORY

Name: _____ Birthdate: _____ Date:_____
Last First Initial

Reason for Today's Visit: _____

Former Dentist: _____ Address: _____

Date of Last Dental Care: _____ Date of Last Dental X-Rays: _____

How Often Do You Brush: _____ How Often Do You Floss: _____

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

☐ Bad Breath ☐ Bleeding Gums ☐ Clicking or Popping Jaw ☐ Food Collection ☐ Grinding Teeth
☐ Loose Teeth or Broken Fillings ☐ Periodontal Treatment ☐ Sensitivity to Biting ☐ Sensitivity to Cold
☐ Sensitivity to Hot ☐ Sensitivity to Sweets ☐ Sore or Growth in Mouth

Physician's Name: _____ Date of Last Visit: _____
Have you had any serious illnesses or operations? _____ If yes describe: _____
Blood pressure _____
Have you ever had a blood transfusion? ◯ Yes ◯ No If yes, give approximate dates: _____

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

☐ AIDS
☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems, Blood Disease
☐ Bleeding abnormally, with extractions or surgery
☐ Cancer
☐ Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Cortisone Treatments
☐ Cough Persistent
☐ Cough of Blood
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Dementia
☐ Do you wear contact lenses?
☐ Fainting / Dizziness
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
Describe_____
☐ Hemophilia
☐ Hepatitis
Type _____
☐ Herpes
☐ High Blood Pressure
☐ HIV Positive
☐ Jaundice
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Skin Rash
☐ Sinus Trouble
☐ Special Diet
☐ Stroke
☐ Swelling of Feet or Ankles
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Tumor or Growth on Head or Neck
☐ Ulcer
☐ Venereal Disease
☐ Weight Loss / Unexplained

☐ Taking Birth Control Pills Chemical
☐ Are you Pregnant? ◯ Yes ◯ No
Due Date:_____
☐ Are You Nursing? ◯ Yes ◯ No

☐ Have you ever taken?
Fen-Phen ◯ Yes ◯ No
Redux ◯ Yes ◯ No

☐ Other:_____

MEDICATIONS

List medications you are currently taking

_____
_____

Pharmacy Name: _____Phone_____

ALLERGIES

☐ Aspirin
☐ Codeine
☐ Erythromycin
☐ Local Anesthetic
☐ Tetracycline
☐ Latex
☐ Penicillin
☐ Sulfa
☐ Other

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his\ her staff responsible for any errors or omissions that I may have made in the completion of the form. Disclaimer: " Dentist makes Patient no promise, representation or warranty of a particular result or outcome of treatment. No Prior written or oral Promise, representation or warranty of a particular result or outcome of treatment made by Dentist, his or her employees, agents or staff shall bind Dentist."

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____