

DENTAL HISTORY

PATIENT NAME: _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Chronic Bad Breath Yes NoBleeding gums Yes NoBlisters on lips or mouth Yes NoBurning sensation on tongue Yes NoChew on one side of mouth Yes NoCigarette, pipe,
or cigar smoking Yes NoClicking or popping jaw Yes NoDry mouth Yes NoFingernail chewing Yes NoFood collection between teeth Yes NoGrinding teeth Yes NoGums Swollen or tender Yes NoJaw pain or tenderness Yes NoLip or cheek biting Yes NoLoose tth. or broken fillings Yes NoMouth breathing Yes NoMouth pain upon brushing Yes NoOrthodontic treatment Yes NoPain around ear Yes NoPeriodontal treatment Yes NoSensitivity to hot Yes NoSensitivity to cold Yes NoSensitivity to sweets Yes NoSensitivity when biting Yes NoSores or growths in
your mouth Yes No

How often do you floss? _____

How often do you brush? _____

Other information _____

Health History

Physician's Name & Hospital _____

Date of last visit _____

AIDS Yes NoAnemia Yes NoArthritis, Rheumatism Yes NoArtificial Heart Valves Yes NoArtificial Joints Yes NoAsthma Yes NoAbnormal bleeding Yes NoBlood Disease Yes NoCancer Yes NoChemical Dependency Yes NoChemotherapy Yes NoCirculatory Problems Yes NoCongenital Heart Problems Yes NoCough, persistent/bloody Yes NoDiabetes Yes NoDrugs: Recreational Yes NoEmphysema Yes NoEpilepsy Yes NoFainting or dizziness Yes NoFibromyalgia Yes NoGlaucoma Yes NoHeadaches Yes NoHeart Murmur Yes NoHeart Disease Yes NoHepatitis type _____ Yes NoHerpes Yes NoHigh Blood Pressure Yes NoHIV Positive Yes NoJaundice Yes NoJaw Pain Yes NoKidney Disease Yes NoLiver Disease Yes NoLow Blood Pressure Yes NoMitral Valve Prolapse Yes NoNervous Disorders Yes NoPacemaker Yes NoPhen-fen Yes NoRadiation Treatment Yes NoRespiratory Disease Yes NoRheumatic Fever Yes NoScarlet Fever Yes NoShortness of Breath Yes NoSinus Problems Yes NoStroke Yes NoThyroid Problems Yes NoTuberculosis Yes NoTumors/Growths Yes NoUlcers Yes NoVenereal Disease Yes NoPregnant Yes NoBirth Control Yes No**MEDICATIONS**

List medications you are currently taking:

Pharmacy Name _____

Phone Number _____ City _____

ALLERGIES yes no Aspirin Latex Barbiturates Local Anesthetic Codeine Penicillin Iodine Sulfa Other _____

The information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status or insurance coverage. Written authorization is required for the release of any personal information including but not limited to x-rays, notes, etc. I authorize the dental staff to perform necessary dental services that I may need during the diagnosis and treatment of my dental condition, including but not limited to oral examinations, x-rays, and prophylaxis.

Patient or Parent Signature _____

Doctor Signature _____ Date _____

(Year 2 Changes) _____

Pt. Signature _____ Date _____ Dr. _____

BP _____ / _____

PULSE _____

BP _____ / _____

PULSE _____