DENTAL HISTORY Name:_____DOB:_____

Check the appropriate box if you have ever had or currently have the following:

	Y	N		Y	N		Y	N
Bad breath	☐	☐	**Chewing ice**	☐	☐	**Fever blisters in mouth or on lips**	☐	☐
Grinding/Clenching teeth	☐	☐	**Pain around ear or jaw**	☐	☐	**Cold sores or growths in mouth**	☐	☐
Bleeding or sore gums	☐	☐	**Chewing on one side of mouth**	☐	☐	**Problems with extractions or surgery**	☐	☐
Dry Mouth	☐	☐	**Food collection between teeth**	☐	☐	**Excessive bleeding from an extraction**	☐	☐
Mouth Breathing	☐	☐	**Mouth pain while brushing**	☐	☐	**Orthodontic Treatment (Braces)**	☐	☐
Lip or cheek biting	☐	☐	**Loose teeth or fillings**	☐	☐	**Periodontal Treatment (Gum Surgery)**	☐	☐
Fingernail biting	☐	☐	**Clicking or popping of jaw**	☐	☐	**Dentures? Partial (U/L) Full (U/L)**		☐

Sensitivity to: (circle) cold heat sweets when biting where?_____
Reason for today's visit_____
Former Dentist:_____City:_____State:_____Zip:_____
Date of last dental visit:_____Date of last dental x-rays taken:_____ How many and what type?_____
How often do you: Brush ?_____Floss?_____ Have you ever had an unfavorable reaction to a local anesthetic? _____
Do you feel nervous about having dental treatment?_____ Do you have pain or any problems anywhere in your mouth?_____
Do you like your smile?_____ Do you feel that it can be improved?_____

HEALTH HISTORY

Physician's Name:_____Phone:_____Date of Last visit:_____

Check the appropriate box if you have ever had or currently have the following:

	Y	N		Y	N		Y	N		Y	N
AIDS (HIV)	☐	☐	**Arthritis, Rheumatism**	☐	☐	**Glaucoma**	☐	☐	**Swollen neck glands**	☐	☐
Artificial Heart Valve	☐	☐	**Artificial Joints (knee, hip)**	☐	☐	**Headaches**	☐	☐	**Thyroid Problems**	☐	☐
Diet Pills/ Phen-Fen	☐	☐	**Asthma**	☐	☐	**Herpes**	☐	☐	**Tonsillitis**	☐	☐
Heart Murmur	☐	☐	**Back Problems**	☐	☐	**Kidney Disease**	☐	☐	**Tobacco use: smoke ☐ chew ☐**		☐
Heart Problems	☐	☐	**Blood Disease**	☐	☐	**Liver Disease**	☐	☐	**Tuberculosis**	☐	☐
Describe_____			**Blood Transfusion**	☐	☐	**Low Blood Pressure**	☐	☐	**Tumor/growth on head/neck**	☐	☐
Bisphos meds (fosamax)	☐	☐	**Hepatitis: Type_____**	☐	☐	**High Blood Pressure**	☐	☐	**Ulcer**	☐	☐
Congestive Heart Failure	☐	☐	**Cancer: Type_____**	☐	☐	**MAOI drugs**	☐	☐	**Respiratory Disease (Lung)**	☐	☐
Angina	☐	☐	**Chemotherapy/ Radiation**	☐	☐	**Scarlet Fever**	☐	☐	**Venereal Disease**	☐	☐
Mitral Valve Prolapse	☐	☐	**Circulatory Problems**	☐	☐	**Shortness of Breath**	☐	☐	**Wear contact lenses**	☐	☐
Pacemaker	☐	☐	**Cortisone Treatments**	☐	☐	**Sinus Trouble**	☐	☐	**Weight change, unexplained**	☐	☐
Rheumatic Fever	☐	☐	**Cough, persistent or bloody**	☐	☐	**Skin Rash**	☐	☐	**Women:**		
Alcohol/drug abuse	☐	☐	**Diabetes**	☐	☐	**Special Diet**	☐	☐	**Are you pregnant?**	☐	☐
Anemia	☐	☐	**Epilepsy/ seizures**	☐	☐	**Stroke**	☐	☐	**Are you nursing?**	☐	☐
Fainting or dizziness	☐	☐	**Swelling of feet or ankles**	☐	☐				**Using Birth Control Pills?**	☐	☐

Tobacco use: amount? _____ how long?_____
Is there any condition not listed that you have? _____

MEDICATIONS:

Check here if you are not taking any medications ☐

List any medications you are currently taking:
(*Including Vitamins, Herbal medicines*)

_____
_____
_____
_____
_____
_____
_____

Pharmacy Name:_____
Phone:_____

ALLERGIES:

Check here if you have no known allergies ☐

- ☐ **Aspirin**
- ☐ **Codeine**
- ☐ **Erythromycin**
- ☐ **Latex**
- ☐ **Local Anesthetic (Novocaine)**
- ☐ **Motrin**
- ☐ **Penicillin/Amoxicillin**
- ☐ **Sulfa**
- ☐ **Valium**
- ☐ **Other:**

(*Food or Medicine*)

_____
_____
_____

Blood Pressure:_____
(*OFFICE USE ONLY*)

CONSENT:

The information on this questionnaire is accurate to the best of my knowledge. I understand this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in medical status, I will inform the dentist. The undersigned hereby authorizes the doctor or doctor's staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Refusal of diagnostic aids at any time will release the doctor of responsibility for early diagnosis. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated.

Patient or Responsible Party (parent/guardian of minor) :_____ Date:_____

Doctor's Signature:_____ Date:_____