



DENTAL HEALTH HISTORY

Name: _____

Reason for today's visit _____

Former Dentist _____

Phone _____

Date of last dental exam _____

Date of last dental x-rays _____

Date of last cleaning _____

How often do you brush? _____

How often do you floss? _____

Do you feel pain anywhere? _____

Describe _____

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

Sensitivity to hot or cold	Yes	No
Sensitivity to sweet	Yes	No
Avoid one side of the mouth when chewing	Yes	No
Sensitivity when biting	Yes	No
Broken/cracked fillings	Yes	No
Food collection between teeth	Yes	No
Tobacco use	Yes	No
Gums swollen or tender	Yes	No
Gums bleed frequently	Yes	No

Blisters on lips or mouth	Yes	No
Scores or growths inside cheek / in the mouth	Yes	No
Bad breath	Yes	No
Burning sensation on tongue	Yes	No
Dry mouth	Yes	No
Accident involving jaw	Yes	No
Clicking or popping jaw	Yes	No
Frequent headaches	Yes	No
Grinding teeth	Yes	No
Jaw pain or tiredness	Yes	No
Pain around ear	Yes	No
Orthodontic treatment	Yes	No
Periodontal treatment	Yes	No

MEDICAL HEALTH HISTORY

Physician _____ Phone _____

Please list all current medications (including prescription, over-the-counter, herbal supplements) and reason for use:

Are you allergic to any of the following?

Aspirin Codeine Latex Penicillin Valium

Other: _____

Have you ever had any of the following conditions?

Artificial Joint/Valve Heat Murmur
 Mitral Valve Prolapsed Rheumatic Fever

WOMEN ONLY:

Do you use birth control medication?	Yes	No
Are you nursing?	Yes	No
Are you pregnant? (Due date:)	Yes	No

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

AIDS / HIV	Yes	No
Anemia	Yes	No
Arthritis or Back problems	Yes	No
Asthma or Respiratory problems	Yes	No
Blood transfusion (Date: _____)	Yes	No
Cancer	Yes	No
Cardiac pacemaker	Yes	No
Convulsions / Epilepsy / Seizures	Yes	No
Diabetes	Yes	No
Excessive bleeding with surgery / extractions	Yes	No
Heart problems	Yes	No
Hepatitis or Liver problems	Yes	No
High or Low blood pressure	Yes	No
Kidney problems	Yes	No
Phen-Phen treatments	Yes	No
Radiation or Chemotherapy treatment	Yes	No
Sexually transmitted disease	Yes	No
Stroke	Yes	No
Thyroid disorder	Yes	No
Tuberculosis	Yes	No
Other: _____		

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental can be dangerous to my health.

Responsible Party Signature _____

Date: _____

Attending Dentist Signature _____

Date: _____