Patient Name: _____ **DOB:** _____

Dental Health History

Reason for today's visit _____
_____
Former Dentist _____
City/State _____
Date of last dental visit _____
Date of last dental x-rays _____
Indicate if you have had any of the following:

Bad Breath	☐Y	☐N	**Chew tobacco**	☐Y	☐N	**Mouth breathing**	☐Y	☐N
Bleeding Gums	☐Y	☐N	**Cigarette, pipe, cigar smoking**	☐Y	☐N	**Mouth pain when brushing**	☐Y	☐N
Blisters on lips or mouth	☐Y	☐N	**Clicking or popping of jaw**	☐Y	☐N	**Orthodontic treatment**	☐Y	☐N
Burning sensation on tongue	☐Y	☐N	**Dry mouth**	☐Y	☐N	**Pain around ear**	☐Y	☐N
Chew on one side of mouth	☐Y	☐N	**Fingernail biting**	☐Y	☐N	**Periodontal treatment**	☐Y	☐N
			Food collection between teeth	☐Y	☐N	**Sensitivity to cold**	☐Y	☐N
			Foreign objects	☐Y	☐N	**Sensitivity to heat**	☐Y	☐N
			Grinding teeth	☐Y	☐N	**Sensitivity to sweets**	☐Y	☐N
			Gums swollen or tender	☐Y	☐N	**Sensitivity when biting**	☐Y	☐N
			Jaw pain or tiredness	☐Y	☐N	**Sores or growths in mouth**	☐Y	☐N
			Lip or cheek biting	☐Y	☐N	**How often do you floss?** _____		
			Loose teeth or broken fillings	☐Y	☐N	**How often do you brush?** _____		

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy name _____

Address _____

ALLERGIES

☐Aspirin or Ibuprofen
☐Barbiturates (sleeping pills)
☐Codeine
☐Iodine
☐Latex
☐Local Anesthetic
☐Penicillin
☐Sulfa
☐Other_____
_____

Medical History

Physician's Name & Telephone Number _____

Date of last visit _____

Place a mark on 'yes' or 'no' to indicate if you have had any of the following:

AIDS/HIV	☐Y	☐N	**Emphysema**	☐Y	☐N	**Psychiatric Care**	☐Y	☐N
Anemia	☐Y	☐N	**Epilepsy/Seizures**	☐Y	☐N	**Radiation Treatment**	☐Y	☐N
Arthritis, Rheumatism	☐Y	☐N	**Fainting or Dizziness**	☐Y	☐N	**Respiratory Disease**	☐Y	☐N
Artificial Heart Valves	☐Y	☐N	**Glaucoma**	☐Y	☐N	**Rheumatic Fever**	☐Y	☐N
Artificial Joints or implants	☐Y	☐N	**Headaches**	☐Y	☐N	**Scarlet Fever**	☐Y	☐N
Asthma	☐Y	☐N	**Heart Murmur**	☐Y	☐N	**Shortness of Breath**	☐Y	☐N
Back Problems	☐Y	☐N	**Heart Problems**	☐Y	☐N	**Sinus Trouble**	☐Y	☐N
Bleeding abnormally w/extractions	☐Y	☐N	**Heart Surgery**	☐Y	☐N	**Skin Rash/Hives**	☐Y	☐N
Blood Disease	☐Y	☐N	**Hepatitis: Type** _____	☐Y	☐N	**Sexually Transmitted Disease**	☐Y	☐N
Cancer	☐Y	☐N	**High Blood Pressure**	☐Y	☐N	**Stroke**	☐Y	☐N
Chemical Dependency	☐Y	☐N	**Jaw Pain**	☐Y	☐N	**Swollen Feet or Ankles**	☐Y	☐N
Chemotherapy	☐Y	☐N	**Kidney disease**	☐Y	☐N	**Thyroid Problems**	☐Y	☐N
Circulatory Problems	☐Y	☐N	**Liver Disease or Jaundice**	☐Y	☐N	**Tonsillitis**	☐Y	☐N
Congenital Heart Lesions	☐Y	☐N	**Low Blood Pressure**	☐Y	☐N	**Tuberculosis**	☐Y	☐N
Cortisone Treatments	☐Y	☐N	**Mitral Valve Prolapse**	☐Y	☐N	**Tumor/Growth Head or Neck**	☐Y	☐N
Cough, persistent or bloody	☐Y	☐N	**Nervous Disorder**	☐Y	☐N	**Ulcers**	☐Y	☐N
Diabetes	☐Y	☐N	**Pacemaker**	☐Y	☐N	**Weight Loss/Unexplained**	☐Y	☐N
Do you wear contact lenses?	☐Y	☐N						

WOMEN:

Are you pregnant?	☐Y	☐N	**Due Date** _____	**Are you nursing?**	☐Y	☐N
Taking birth control pills?	☐Y	☐N				

_____

Signed: Patient or Parent/Guardian for minor ***Date***