DENTAL HEALTH HISTORY
Confidential

Today's Date _____

Patient Name _____ Birthdate _____
Last First Initial

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____
Former Dentist _____ Date of last dental X-rays _____
Address _____

Check (√) if you have had problems with any of the following:

☐ Bad Breath
☐ Bleeding Gums
☐ Clicking or popping jaw
☐ Food collection between teeth
☐ Grinding Teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in your mouth

How often do you floss: _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____
Have you had any serious illnesses or operations? _____ If yes, describe _____
Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____
Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of tonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (√) if you have or have had any of the following:

☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough up Blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ HIV/AIDS
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Skin Rash
☐ Stroke
☐ Swelling of Feet or Ankles
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____
Phone _____

ALLERGIES

☐ Aspirin ☐ Penicillin
☐ Barbiturates (Sleeping Pills) ☐ Sulfa
☐ Codeine ☐ Latex _____
☐ Local Anesthetic ☐ Other

SIGNATURE

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 this form.

Date _____ Signature _____