**PLEASE COMPLETE ALL INFORMATION – THANK YOU!**

**PATIENT LAST NAME:** _____ **PATIENT FIRST NAME:** _____

## DENTAL HISTORY

Reason for today's visit: _____ Date of last dental visit: _____

Former dentist: _____ Date of last dental x-rays: _____

**Please check if you have/had:**

| | | | | | |
|---|---|---|---|---|---|
| Bad breath | ☐ | Gums swollen, tender, or bleeding | ☐ | Have you ever had an allergic reactions | ☐ |
| Blisters on lips or mouth | ☐ | Head, neck, or jaw pain or aches | ☐ | to Novocaine, local or general anesthetics? | |
| Burning sensation on tongue | ☐ | Lip or cheek biting | ☐ | *If Yes, please explain:* | |
| Chew on one side of mouth | ☐ | Loose teeth or broken fillings | ☐ | _____ | |
| Cigarette, pipe, or cigar smoking | ☐ | Mouth breathing | ☐ | | |
| Smokeless tobacco | ☐ | Orthodontic treatment | ☐ | Have you had trouble from previous | ☐ |
| Dry mouth | ☐ | Nitrous Oxide | ☐ | dental care? | |
| Food collection between teeth | ☐ | Periodontal treatment | ☐ | *If Yes, please explain what happened:* | |
| Clench teeth | ☐ | Sensitivity to pressure or irritants | ☐ | _____ | |
| Grind teeth | ☐ | (cold, heat, sweets) | | _____ | |
| Growths or sore spots in mouth | ☐ | How often do you floss? _____ | | | |
| | | How often do you brush? _____ | | | |

## MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____

Physician's address: _____

Have you ever had a blood transfusion? Yes ☐ If Yes, please describe: _____

Have you had any serious illnesses or operations? Yes ☐ If Yes, please give approximate dates: _____

Pregnant? Yes ☐ Due Date? _____ Nursing? Yes ☐ Birth Control Pills? Yes ☐

**Please check if you have/had:**

| | | | | | |
|---|---|---|---|---|---|
| Allergies, hay fever, sinusitis | ☐ | Heart Problems | ☐ | Thyroid Problems | ☐ |
| Anemia | ☐ | Hepatitis? | ☐ | Tonsillitis | ☐ |
| Arthritis, Rheumatism | ☐ | Type: _____ | | Tuberculosis | ☐ |
| Artificial Heart Valves | ☐ | Herpes | ☐ | Tumor or Growth on Head/Neck | ☐ |
| Artificial Joints | ☐ | High Blood Pressure | ☐ | Ulcer | ☐ |
| Asthma | ☐ | Any Immune Deficiency (incl. HIV/AIDS) | ☐ | Venereal Disease | ☐ |
| Asthma: Required Hospitalization | ☐ | Jaundice | ☐ | Weight Loss, Unexplained | ☐ |
| Asthma: Used Steroids | ☐ | Kidney Disease | ☐ | Do you wear contact lenses? | ☐ |
| Bleeding abnormally with operation/surgery | ☐ | Low Blood Pressure | ☐ | Do you consume alcoholic beverages? | ☐ |
| Blood Disease, Clotting Disorders | ☐ | Mitral Valve Prolapse | ☐ | Are you currently under the care of a | ☐ |
| Cancer | ☐ | Osteopenia | ☐ | Physician? | |
| Chemical Dependency | ☐ | Osteoporosis | ☐ | Are you allergic/sensitive to Latex? | ☐ |
| Chemotherapy | ☐ | Pacemaker | ☐ | Allergic to penicillin, Aspirin or Other Drugs? | ☐ |
| Circulatory Problems | ☐ | Radiation Treatments | ☐ | *If Yes, please specify:* | |
| Cortisone Treatments | ☐ | Respiratory Disease | ☐ | _____ | |
| Cough, persistent or bloody | ☐ | Rheumatic Fever | ☐ | _____ | |
| Diabetes | ☐ | Scarlet Fever | ☐ | Are you currently taking any Medications? | ☐ |
| Emphysema | ☐ | Shortness of Breath | ☐ | *If Yes, please list:* | |
| Epilepsy | ☐ | Sinus Trouble | ☐ | _____ | |
| Fainting | ☐ | Sickle Cell Anemia | ☐ | _____ | |
| Glaucoma | ☐ | Skin Rash | ☐ | _____ | |
| Headaches | ☐ | Stroke | ☐ | _____ | |
| Heart Murmur | ☐ | Swelling of Feet/Ankles | ☐ | _____ | |

## AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____



# DENTAL & MEDICAL HEALTH HISTORY