DENTAL HEALTH HISTORY

(Confidential)

Today's Date_____

Patient Name _____ Birthday _____

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of last dental care _____ Date of last dental X-rays _____

Check if you have had problems with any of the following

Bad Breath	Food collection between teeth	Sensitivity to hot
Bleeding gums	Grinding teeth	Sensitivity to sweets
Clicking or popping jaw	Loose teeth or broken fillings	Sensitivity when biting
Difficulties in chewing	Periodontal treatment	Sores or growths in mouth
Esthetic concerns	Sensitivity to cold	Teeth too dark

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? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, gives approximate dates _____

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

Have you ever taken diet pills? Yes No If yes, please list_____

Check if you have or had any of the following:

AIDS	Circulatory Problems	Hemophilia	Radiation Treatment
Alzheimer Disorder	Cortisone Treatments	Hepatitis	Respiratory Disease
Anemia	Cough, Persistent	High Blood Pressure	Rheumatic Fever
Arthritis, Rheumatism	Diabetes	HIV Positive	Scarlet Fever
Artificial Heart Valve	Eating Disorder	Jaw Pain	Skin Rash
Artificial Joints	Epilepsy	Kidney Disease	Stroke
Asthma	Fainting	Liver Disease	Swelling of feet/ankles
Blood Disease	G.E.R.D.	Mitral Valve Prolapse	
Bulimia	Glaucoma	Nervous Problems	Tobacco Habit
Cancer	Headaches	Osteoporosis	Thyroid Problems
Chemical Dependency	Heart Murmur	Pacemaker	Tuberculosis
Chemotherapy	Heart Problems	Psychiatric Care	Ulcer

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

Aspirin	Penicillin
Barbiturates	Sulfa
Codeine	
Local Anesthetic	Other _____

_____

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*** _____