

DENTAL HISTORY



Name: _____ Are you in dental discomfort today? _____
Former Dentist _____ Date of last dental care _____
Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following: Y N Loose teeth Y N Bad Breath
 Y N Periodontal treatment Y N Food collection between teeth Y N Mouth sores
 Y N Broken Fillings Y N Bleeding gums Y N Sensitivity to cold Y N Sensitivity to sweets
 Y N Sensitivity when biting Y N Clicking or popping jaw Y N Sensitivity to hot

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Other information about your dental health or previous treatment: _____

MEDICAL HISTORY

Are you currently under physician care? Y N If yes, describe _____

Physician's name _____ Phone _____

Date of last visit _____ Blood Transfusion Y N Dates: _____

Have you had any serious illness or operations recently? If yes, Describe _____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check (✓) yes or no whether you have had any of the following (Please circle which applies):

- | | | |
|---|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Dental implants | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure/ Circulatory problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease | <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis A, B or C | <input type="checkbox"/> Y <input type="checkbox"/> N Cold sores/Fever blisters | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal Bleeding |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Care/ Nervous problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of limbs | <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy/ Radiation treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco Habit | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol Dependency/Drug Addiction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints/Artificial heart valves |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur/ Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery/ Heart Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease | <input type="checkbox"/> Y <input type="checkbox"/> N Hay fever/Hives or rash | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma / Respiratory disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting/Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Material/Food Allergies – |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | | (latex, wool, metal, chemicals, Peanuts, Shellfish) |

Is patient currently taking any medications? If yes, list all:

Does patient have drug allergies? If yes, list all:

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature of Patient, Parent, or Guardian _____ Date _____

Doctor's Signature _____