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):

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