Dental History

Patient's Name:_____ Date of Birth:_____
Reason for today's visit:_____ Date of last dental visit/x-rays:_____
Former Dentist:_____ City/St.:_____

Place a mark on any boxes that indicate that you have had any of the following:

☐ Bad Breath
☐ Bleeding Gums
☐ Blisters on lips or mouth
☐ Clicking or popping jaw
☐ Dry mouth
☐ Food collection between teeth
☐ Grinding teeth
☐ Gums swollen or tender
☐ Injury to head, neck or mouth
☐ Jaw pain or tiredness
☐ Loose teeth or broken fillings
☐ Mouth breathing
☐ Orthodontic Treatment
☐ Pain around ear
☐ Periodontal Treatment
☐ Sensitivity to cold
☐ Sensitivity to heat
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growth in mouth
☐ Tobacco use

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

Medical History

Physician's Name:_____ Date of last visit:_____
Have you ever taken Fosamax, Boniva, Actonel for osteoporosis or any cancer medication containing Bisphosphonates? ☐ Yes ☐ No If yes, please describe_____

Place a mark on any boxes to indicate if you have had any of the following:

☐ Aids/HIV
☐ Anemia
☐ Angina
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Bleeding Problems
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Congenital Heart Disorder
☐ Diabetes
☐ Eating Disorders
☐ Emphysema
☐ Epilepsy/Seizures
☐ Dizziness
☐ Glaucoma
☐ Headaches
☐ Heart Attack
☐ Hepatitis Type____
☐ Herpes
☐ High Blood Pressure
☐ Intestinal Disease
☐ Jaundice
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Health Disorder
☐ Osteoporosis
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Sinus Troubles
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumor or Growth on head or neck
☐ Ulcer
☐ Sexually Transmitted Disease
☐ Weight Loss, Unexplained

Have you had any serious illness/condition/hospitalization not listed above?_____

_____

_____

Women: Are you pregnant? ☐ Yes ☐ No Due Date:_____ Are you nursing? ☐ Yes ☐No
Are you taking birth control pills? ☐ Yes ☐ No

Medications

Please list any medications you are currently taking:

_____

_____

_____

Drug Allergies:

☐ Aspirin
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Metals
☐ Penicillin
☐ Other_____

Patient Signature:_____ Date:_____