DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit_____ Date of last dental care_____

Former Dentist_____ Date of last X-rays_____

Address _____

Check (✔) if you have had experience or problems with any of the following

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth
☐ Snoring	☐ What would you change about your smile?_____	

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

MEDICATIONS

List any prescription or over-the-counter medications you are currently taking: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone (_____)_____

Medical History

Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name: _____ **Phone:** _____ **Date of last medical exam:** _____

What was the exam for? _____ **Current Physician:** _____

	Y	N
Have you ever been hospitalized or had a major operation?	☐	☐
Are you under the care of a physician?	☐	☐
Have you ever had a serious head or neck injury?	☐	☐
Are you taking any medications or supplements?	☐	☐
If yes please list, the dose and how often:		
(use back of paper if needed)		
Do you take or have you taken Phen-Fen or Redux?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	☐
Are you on a special diet?	☐	☐
Do you use Tobacco?	☐	☐
Do you use controlled substances?	☐	☐

Women

	Y	N
Are you pregnant or trying to get pregnant?	☐	☐
Are you taking contraceptives?	☐	☐
Are you nursing?	☐	☐

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Local Anesthetics
- ☐ Acrylic
- ☐ Codeine
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Other

CHECK ALL THAT APPLY:

FAMILY HISTORY UNKNOWN? ☐ **YES** ☐ **NO**

	HAVE	HAD	FAMILY HISTORY
Acid Reflux	☐	☐	☐
AIDS\HIV Positive	☐	☐	☐
Alzheimer's Disease	☐	☐	☐
Anaphylaxis	☐	☐	☐
Anemia	☐	☐	☐
Angina	☐	☐	☐
Arthritis\Gout	☐	☐	☐
Artificial Heart Valve	☐	☐	☐
Artificial Joint:	☐	☐	☐
What Joint? _____			
When? _____			
Asthma	☐	☐	☐
Blood Disease	☐	☐	☐
Blood Transfusion	☐	☐	☐
Breathing Problem	☐	☐	☐
Bruise Easily	☐	☐	☐
Cancer	☐	☐	☐
Type? _____			
Chemotherapy	☐	☐	☐
When? _____			
Chest Pains	☐	☐	☐
Cold Sores\Fever Blisters	☐	☐	☐
Congenital Heart Disorder	☐	☐	☐
Convulsions	☐	☐	☐
Cortisone Medicine	☐	☐	☐
Diabetes	☐	☐	☐
Drug Addiction	☐	☐	☐
Dry Mouth	☐	☐	☐
Easily Winded	☐	☐	☐
Emphysema	☐	☐	☐
Epilepsy\Seizures	☐	☐	☐
Excessive Bleeding	☐	☐	☐
Excessive Thirst	☐	☐	☐
Fainting Spells\Dizziness	☐	☐	☐
Frequent Cough	☐	☐	☐
Frequent Diarrhea	☐	☐	☐
Frequent Headaches	☐	☐	☐
Genital Herpes	☐	☐	☐
Glaucoma	☐	☐	☐
Hay Fever	☐	☐	☐
Heart Attack\Failure	☐	☐	☐
Heart Murmur	☐	☐	☐
Heart Pace Maker	☐	☐	☐
Heart Trouble\Disease	☐	☐	☐
Hemophilia	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B or C	☐	☐	☐
Herpes	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Hives or Rash	☐	☐	☐
Hypoglycemia	☐	☐	☐
Inflammatory disease	☐	☐	☐
Type? _____			
Irregular Heartbeat	☐	☐	☐
Kidney Problems	☐	☐	☐
Leukemia	☐	☐	☐
Liver Disease	☐	☐	☐
Low Blood Pressure	☐	☐	☐
Lung Disease	☐	☐	☐
Mitral Value Prolapse	☐	☐	☐
Osteoporosis	☐	☐	☐
Pain in Jaw Joints	☐	☐	☐
Parathyroid Disease	☐	☐	☐
Psychiatric Care	☐	☐	☐
Radiation Treatments	☐	☐	☐
When? _____			
Recent Weight Loss	☐	☐	☐
Renal Dialysis	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Rheumatism	☐	☐	☐
Scarlet Fever	☐	☐	☐
Shingles	☐	☐	☐
Sickle Cell Disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sleep Apnea	☐	☐	☐
Did you wear a c-pap? **Y** ☐ **N** ☐			
Spina Bifida	☐	☐	☐
Stomach\Intestinal Disease	☐	☐	☐
Stroke	☐	☐	☐
Swelling of Limbs	☐	☐	☐
Thyroid Disease	☐	☐	☐
Tonsillitis	☐	☐	☐
Tuberculosis	☐	☐	☐
Tumors or Growths	☐	☐	☐
Ulcers	☐	☐	☐
Venereal Disease	☐	☐	☐
Yellow Jaundice	☐	☐	☐

HAVE EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ **YES** ☐ **NO**

If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ **Date:** _____