PATIENT DENTAL HISTORY

PATIENT NAME _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	❍	❍
2. Are your teeth sensitive to hot or cold?	❍	❍
3. Are your teeth sensitive to sweet or sour liquids/foods?	❍	❍
4. Do you feel pain in any of your teeth?	❍	❍
5. Do you have any sores or lumps in or near your mouth?	❍	❍
6. Have you had any head, neck or jaw injuries?	❍	❍
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	❍	❍
b) Pain (joint, ear, side of face)?	❍	❍
c) Difficulty in opening or closing?	❍	❍
d) Difficulty in chewing?	❍	❍
8. Do you have frequent headaches?	❍	❍
9. Do you clench or grind your teeth?	❍	❍
10. Do you bite your lips or cheeks frequently?	❍	❍
11. Have you ever had any difficult extractions in the past?	❍	❍
13. Have you ever had prolonged bleeding following extractions?	❍	❍
12. Have you had any orthodontic work?	❍	❍
14. Have you ever had instruction on the correct method of brushing your teeth?	❍	❍
15. Have you ever had instructions on the care of your gums?	❍	❍

What is the reason for your visit today? _____

_____

Date of last dental visit _____ Previous Dentist _____

What was done at your last dental visit? _____

_____

Are you satisfied with your teeth's appearance? ❍ Yes ❍ No

What would you change about your smile? _____

Do you brush, floss or use any other dental aids? _____

Is there anything else about having dental treatment that you would like us to know? ❍ Yes ❍ No

If yes, please describe _____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____ _____

PATIENT, PARENT OR GUARDIAN **DATE**

MEDICAL HEALTH HISTORY

PATIENT NAME: _____ **DATE:** _____

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST PHYSICAL _____

HEIGHT _____ WEIGHT _____ INDICATE ANY PREMEDICATIONS _____

	YES	NO
1. Are you under medical treatment now? If yes, for what? _____	❍	❍
2. Have you ever been hospitalized for any surgical operation or serious illness? If yes, for what? _____	❍	❍
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s)/vitamins are you taking? _____	❍	❍
4. Do you use tobacco?	❍	❍
5. Do you use alcohol?	❍	❍
6. Do you use recreational drugs?	❍	❍

7. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
❍	❍	Local anesthetics	❍	❍	Sedatives	❍	❍	Iodine
❍	❍	Penicillin or other antibiotics	❍	❍	Food Allergies	❍	❍	Metal
			❍	❍	Codeine	❍	❍	Other
❍	❍	Sulfa drugs	❍	❍	Erythromycin			_____
❍	❍	Latex	❍	❍	Aspirin			_____

8. WOMEN ONLY:

	YES	NO
Are you pregnant or think you may be pregnant?	❍	❍
Are you nursing?	❍	❍
Are you taking birth control pills?	❍	❍

9. Do you <u>have</u> or <u>have you had</u> any of the following?

YES	NO		YES	NO		YES	NO	
❍	❍	Aids or HIV Infection	❍	❍	Frequently Tired	❍	❍	Liver Disease
❍	❍	Anemia	❍	❍	Glaucoma	❍	❍	Low Blood Pressure
❍	❍	Angina	❍	❍	Hay Fever/Allergies	❍	❍	Osteoporosis
❍	❍	Arthritis	❍	❍	Heart Attack	❍	❍	Radiation Therapy
❍	❍	Asthma	❍	❍	Heart Disease	❍	❍	Recent Weight Loss
❍	❍	Blood Transfusion	❍	❍	Heart Murmur	❍	❍	Respiratory Problems
❍	❍	Cancer	❍	❍	Heart Trouble	❍	❍	Rheumatic Fever
❍	❍	Cardiac Pacemaker	❍	❍	Hemophilia	❍	❍	Sexually Transmitted Disease
❍	❍	Chest Pains	❍	❍	Hepatitis/Jaundice	❍	❍	Shingles
❍	❍	Colitis	❍	❍	High Blood Pressure	❍	❍	Sleep Apnea
❍	❍	Diabetes Type I or II	❍	❍	High Cholesterol	❍	❍	Stomach Troubles/Ulcers
❍	❍	Easily Winded	❍	❍	Hyper/Hypo Thyroid	❍	❍	Stroke
❍	❍	Emphysema	❍	❍	Joint Replacement or Implant	❍	❍	Swollen Ankles
❍	❍	Epilepsy/Convulsions	❍	❍	Kidney Diseases	❍	❍	Tuberculosis
❍	❍	Fainting /Seizures	❍	❍	Leukemia	❍	❍	Other _____

COMMENTS _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.
I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____ _____

PATIENT, PARENT OR GUARDIAN **DATE**

Continued on back ➔