Health History

Dental Health

Patient Name____

Reason for today's visit______________________________ Date of last dental care____________________

Former dentist____________________________________ Date of last dental x-rays___________________

Check (✓) if you have had problems with any of the following:

☐ Bad Breath	☐ Grinding	☐ Jaw Pain
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity when biting
☐ Clicking or popping of jaw	☐ Periodontal treatment	☐ Sores or growths in your mouth
☐ Food collecting between teeth	☐ Sensativity to hot/cold	

How often do you floss?_________________________ How often do you brush?_________________________

Medical History

Physician's Name____________________________________ Date of last visit__________________________

Have you had any serious illnesses or operations? If yes, describe______________________________________

____

Have you ever had a blood transfusion? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had the following:

☐ Anemia	☐ Epilepsy	☐ Respiratory Disease
☐ Arthritis, Rheumatism	☐ Fainting	☐ Rheumatic Fever
☐ Artificial Heart Valves	☐ Glaucoma	☐ Scarlet Fever
☐ Artificial Joints	☐ Headaches	☐ Shortness of Breath
☐ Asthma	☐ Heart Murmur	☐ Skin Rash
☐ Back Problems	☐ Heart Problems	☐ Stroke
☐ Blood Disease	☐ Hemophilia	☐ Swelling of Feet or Ankles
☐ Cancer	☐ Hepatitis	☐ Thyroid Problems
☐ Chemical Dependency	☐ High Blood Preasure	☐ Tobacco Habit
☐ Chemotherapy	☐ HIV/AIDS	☐ Tonsillitis
☐ Circulatory Problems	☐ Kidney Disease	☐ Tuberculosis
☐ Cortisone Treatment	☐ Liver Disease	☐ Ulcer
☐ Cough, Persistent	☐ Mitral Valve Prolapse	☐ Venereal Disease
☐ Coughing up blood	☐ Pacemaker	
☐ Diabetes	☐ Radiation Treatment	

Medications	Allergies	
List medications you are currently taking:_______________	☐ Aspirin	☐ Sulfa
____	☐ Barbiturates	☐ Latex
____	☐ Codeine	☐ None
Pharmacy Name: _______________________________	☐ Local Anesthetic	Other_______________
Pharmacy Phone Number: ________________________	☐ Penicillin	____________________

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of her staff responsible for any errors or omissions that may have been made in the completion of this form.

Patient Signature____Date__________________________

Doctor Signature____Date__________________________