**Dental History**

Reason for visit today\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental Cleaning\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental x-rays\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of water do you have? Well \_\_\_\_ City \_\_\_\_

Do you take fluoride supplements? Yes \_\_\_\_ No \_\_\_\_

What type of tooth brush are you using? Hard\_\_\_\_ Medium \_\_\_\_ Soft\_\_\_\_ Electric\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Yes\_\_\_ No\_\_\_ Bad Breath  | Yes\_\_\_ No\_\_\_ Gum swollen or tender | Yes\_\_\_ No\_\_\_ Periodontal treatment |
| Yes\_\_\_ No\_\_\_ Bleeding Gums | Yes\_\_\_ No\_\_\_ Jaw pain or tiredness | Yes\_\_\_ No\_\_\_ Sensitivity cold |
| Yes\_\_\_ No\_\_\_ Blisters on lips/mouth | Yes\_\_\_ No\_\_\_ Lip or cheek biting | Yes\_\_\_ No\_\_\_ Sensitivity hot |
| Yes\_\_\_ No\_\_\_ Burning Sensation on tongue | Yes\_\_\_ No\_\_\_ Loose teeth | Yes\_\_\_ No\_\_\_ Sensitivity sweets |
| Yes\_\_\_ No\_\_\_ Clicking or popping in jaw | Yes\_\_\_ No\_\_\_ Lost fillings | Yes\_\_\_ No\_\_\_ Sensitivity biting |
| Yes\_\_\_ No\_\_\_ Dry Mouth | Yes\_\_\_ No\_\_\_ Mouth breathing | Yes\_\_\_ No\_\_\_ Sores or growths in mouth |
| Yes\_\_\_ No\_\_\_ Food collection between teeth | Yes\_\_\_ No\_\_\_ Mouth pain, brushing | Yes\_\_\_ No\_\_\_ Smokeless tobacco |
| Yes\_\_\_ No\_\_\_ Foreign Objects | Yes\_\_\_ No\_\_\_ Orthodontic treatment | Yes\_\_\_ No\_\_\_ Tobacco habit |
| Yes\_\_\_ No\_\_\_ Grinding teeth | Yes\_\_\_ No\_\_\_ Partial(s) or Denture(s) |  |

**Medical History** Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Yes\_\_\_ No\_\_\_ Aids | Yes\_\_\_ No\_\_\_ Hay Fever | Yes\_\_\_ No\_\_\_ Recent Weight Loss |
| Yes\_\_\_ No\_\_\_ Anemia | Yes\_\_\_ No\_\_\_ Headaches | Yes\_\_\_ No\_\_\_ Respiratory Disease |
| Yes\_\_\_ No\_\_\_ Anxiety/Panic Attacks | Yes\_\_\_ No\_\_\_ Head/Neck injury | Yes\_\_\_ No\_\_\_ Rheumatic Fever |
| Yes\_\_\_ No\_\_\_ Arthritis, Rheumatism | Yes\_\_\_ No\_\_\_ Heart Murmur | Yes\_\_\_ No\_\_\_ Scarlet Fever |
| Yes\_\_\_ No\_\_\_ Artificial Heart Valves | Yes\_\_\_ No\_\_\_ Heart Problems | Yes\_\_\_ No\_\_\_ Shingles |
| Yes\_\_\_ No\_\_\_ Back Problems | Yes\_\_\_ No\_\_\_ Hemophilia | Yes\_\_\_ No\_\_\_ Sickle Cell Disease |
| Yes\_\_\_ No\_\_\_ Bleeding Abnormally | Yes\_\_\_ No\_\_\_ Hepatitis Type\_\_\_\_ | Yes\_\_\_ No\_\_\_ Shortness of Breath |
| Yes\_\_\_ No\_\_\_ Blood Thinner/Aspirin | Yes\_\_\_ No\_\_\_ Herpes | Yes\_\_\_ No\_\_\_ Sinus Trouble |
| Yes\_\_\_ No\_\_\_ Blood Transfusion | Yes\_\_\_ No\_\_\_ High Blood Pressure | Yes\_\_\_ No\_\_\_ Skin Rash |
| Yes\_\_\_ No\_\_\_ Blood Disease | Yes\_\_\_ No\_\_\_ High Cholesterol | Yes\_\_\_ No\_\_\_ Special Diet |
| Yes\_\_\_ No\_\_\_ Bruise Easily | Yes\_\_\_ No\_\_\_ HIV Positive | Yes\_\_\_ No\_\_\_ Spina Bifida |
| Yes\_\_\_ No\_\_\_ Cancer | Yes\_\_\_ No\_\_\_ Hives or Rash | Yes\_\_\_ No\_\_\_ Stroke |
| Yes\_\_\_ No\_\_\_ Chemical Dependency | Yes\_\_\_ No\_\_\_ Hormone Replacement | Yes\_\_\_ No\_\_\_ Swelling of Feet/Ankles |
| Yes\_\_\_ No\_\_\_ Chemotherapy | Yes\_\_\_ No\_\_\_ Hypoglycemia  | Yes\_\_\_ No\_\_\_ Swollen Neck Glands |
| Yes\_\_\_ No\_\_\_ Chest Pains | Yes\_\_\_ No\_\_\_ Jaundice | Yes\_\_\_ No\_\_\_ Tobacco Habit |
| Yes\_\_\_ No\_\_\_ Circulatory Problems | Yes\_\_\_ No\_\_\_ Jaw Pain | Yes\_\_\_ No\_\_\_ Smokeless Tobacco |
| Yes\_\_\_ No\_\_\_ Congenital Heart Lesions | Yes\_\_\_ No\_\_\_ Joint Replacement | Yes\_\_\_ No\_\_\_ Thyroid Problems |
| Yes\_\_\_ No\_\_\_ Convulsions | Yes\_\_\_ No\_\_\_ Kidney Disease | Yes\_\_\_ No\_\_\_ Tonsillitis |
| Yes\_\_\_ No\_\_\_ Cortisone Medicine | Yes\_\_\_ No\_\_\_ Leukemia | Yes\_\_\_ No\_\_\_ Tuberculosis |
| Yes\_\_\_ No\_\_\_ Cough, persistent or bloody | Yes\_\_\_ No\_\_\_ Liver Disease | Yes\_\_\_ No\_\_\_ Tumor or growth on head/neck |
| Yes\_\_\_ No\_\_\_ Diabetes | Yes\_\_\_ No\_\_\_ Low Blood Pressure | Yes\_\_\_ No\_\_\_ Ulcer |
| Yes\_\_\_ No\_\_\_ Drug Addictions | Yes\_\_\_ No\_\_\_ Mitral Valve Prolapse | Yes\_\_\_ No\_\_\_ Venereal Disease |
| Yes\_\_\_ No\_\_\_ Emphysema | Yes\_\_\_ No\_\_\_ Oral Contraceptives | Yes\_\_\_ No\_\_\_ Weight loss, unexplained |
| Yes\_\_\_ No\_\_\_ Excessive Bleeding | Yes\_\_\_ No\_\_\_ Osteoporosis | Yes\_\_\_ No\_\_\_ Chronic Disease |
| Yes\_\_\_ No\_\_\_ Excessive Thirst | Yes\_\_\_ No\_\_\_ Pacemaker |   |
| Yes\_\_\_ No\_\_\_ Do you wear contacts?  |  Women: |   |
| Yes\_\_\_ No\_\_\_ Epilepsy | Yes\_\_\_ No\_\_\_ Are you Pregnant? |   |
| Yes\_\_\_ No\_\_\_ Fainting or dizziness | Yes\_\_\_ No\_\_\_ Are you Nursing? |   |
| Yes\_\_\_ No\_\_\_ Glaucoma |   |   |

**For Office Use Only**

To the best of my knowledge, the questions on the 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 or dental status.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature or patient/Guardian Date**

**Allergies**

□Acrylic □ Latex

**□**Aspirin **□** Local Anesthetic

**□**Barbiturates (Sleeping Pills) **□** Metal

**□**Codeine **□** Penicillin
**□**Iodine **□**Sulfa

**□**Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

List any medications you are currently taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date updated Initials Date updated Initials

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