

**DENTAL HEALTH HISTORY (CONFIDENTIAL)**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
last
first
MI
Birthdate: \_\_\_\_\_

**DENTAL HISTORY**

Reason for today's visit? \_\_\_\_\_

Former Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last dental care: \_\_\_\_\_ Date of last dental X-rays: \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to heat            |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaws      | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Have you had any serious illness or operations? \_\_\_\_\_ Describe: \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates: \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing:  Yes  No Taking Birth Control Pills:  Yes  No

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

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever          |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Shortness of Breath    |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash              |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of Feet/Ankle |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Problems | <input type="checkbox"/> Thyroid Problems       |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tobacco Habit          |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis            |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Chemotherapy            | Describe: _____                               | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                  |
| <input type="checkbox"/> Circulatory Problems    | _____   | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease       |
|  | <input type="checkbox"/> Hemophilia           |  |   |

**MEDICATIONS**

List medications you are currently taking: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**ALLERGIES**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Sulfa        |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Latex        |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Local Anesthetic              | _____                                 |
| <input type="checkbox"/> 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 his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_