Dental History

Name:_____ **Date:**_____

Reason for visit:_____

Date of last cleaning:_____ **Last x-rays:**_____

Do you have any of the following? Check those that apply:

Sensitivity to hot/cold		Crowded teeth		Have you ever been diagnosed with periodontal disease?	
Dry mouth		Bad breath		When?	
Bleeding gums		Food collection		Do you smoke?	
Jaw Pain		Swelling around teeth		How long?	
Discolored teeth		Broken fillings		How often?	
Grinding teeth		Loose teeth		Do you use chewing tobacco?	
Mouth breathing		Braces		How long?	
Lip or cheek biting		Sore on lips		How often?	
Removable retainers or dentures		Sores inside mouth		Night guard	

Medical History

Name of Medical Doctor:_____ **Office:**_____
Are you taking any medications at this time? Please list name and dosage:_____

_____

_____

Are you allergic to any of the following? Check all that apply:

Penicillin		Codeine		Dental Anesthetic	
Latex		Foods		Metals/other materials	
Any other allergies we should be aware of?					

Are you pregnant/do you think you might be pregnant?_____ **Expected Due date:**_____
Have you ever taken a premedication?_____ **For:**_____
Do you have any artificial joints?_____ **Date of surgery:**_____
Have you ever/do you currently use recreational drugs or alcohol?_____
If "yes," please indicate what, when, and how much:_____

Do you have any of the following? Check those that apply:

Abnormal blood pressure		Chronic cough		Heart disease	
Arthritis or rheumatism		Congenital heart lesions		Heart murmur	
Asthma or hay fever		Epilepsy		Heart pacemaker	
Blood disease or anemia		Glaucoma		Sleep apnea	
Chemotherapy/radiation therapy		Head injury		Mitral valve prolapse	
HIV/AIDS		Kidney disorder		Multiple sclerosis	
Jaundice		Leukemia		Parkinson's disease	
Rheumatic fever		Stroke		Psychiatric treatment	
Sinus trouble		Thyroid condition		Tuberculosis or lung disease	
Ulcers		Tumors or growths		Excessive urination	
Prolonged bleeding		Fainting spells		Excessive thirst	
Hepatitis (List type)		STD's (List type)		Diabetes (List type)	

Do you have any other medical problems we need to be aware of?_____
Signature:_____ **Date:**_____

"I certify that there have been no changes to my health."

Please initial and date.

Initial/Date Initial/Date Initial/Date Initial/Date

_____ _____ _____ _____