DENTAL HISTORY

Name _ _____ Date ___/___/_____
Reason for Today's Visit _____

Please Check (☑)	*Yes / No*		*Yes/No*		*Yes/No*
Sensitivity to hot/cold	☐ ☐	Cigarette/pipe/smoking	☐ ☐	Crowded teeth	☐ ☐
Gum disease	☐ ☐	(___ yrs.)		Bad breath	☐ ☐
Sore on lips or in mouth	☐ ☐	Chew tobacco	☐ ☐	Food collection	☐ ☐
Dry mouth	☐ ☐	Chew on one side only	☐ ☐	Swelling around teeth	☐ ☐
Bleeding gums	☐ ☐	Grinding teeth	☐ ☐	Broken fillings	☐ ☐
Jaw pain	☐ ☐	Mouth breathing	☐ ☐	Loose teeth	☐ ☐
Discolored teeth	☐ ☐	Lip or cheek biting	☐ ☐	Braces	☐ ☐

Are you interested in: ☐ bleaching? ☐ veneer? ☐ straighter teeth? ☐ Lumineers?
What would you change about your smile? _____

MEDICAL HISTORY

Name of medical provider: _____ phone # _____
Are you taking medication at this time? ☐ Yes ☐ No
If so, please list and provide dosage. _____
_____
Are you allergic to : ☐ Penicillin ☐ Codeine ☐ Dental anesthetic ☐ Metals/other materials
Are you susceptible to latex allergies? ☐ Yes ☐ No
Do you have any other allergies we should be aware of? _____
Are you pregnant or think you are pregnant? ☐ Yes ☐ No Estimated due date: ___/___/_____
Are you subject to ☐ prolonged bleeding ☐ fainting spells ☐ excessive urination or thirst
Have you ever had any type of radiation therapy (other than diagnostic)? ☐ Yes ☐ No

Please Check (☑)	*Yes / No*		*Yes / No*
Abnormal blood pressure	☐ ☐	Heart pacemaker	☐ ☐
Arthritis or Rheumatism	☐ ☐	Mitral valve prolapsed	☐ ☐
Artificial joints	☐ ☐	Hepatitis	☐ ☐
Date of surgery: ___/___/_____		HIV/AIDS	☐ ☐
Asthma or hay fever	☐ ☐	Jaundice	☐ ☐
Blood disease or anemia	☐ ☐	Kidney disorder	☐ ☐
Chemotherapy	☐ ☐	Leukemia	☐ ☐
Chronic cough	☐ ☐	Multiple sclerosis	☐ ☐
Cold sores or fever blisters	☐ ☐	Parkinson's	☐ ☐
Congenital heart lesions	☐ ☐	Psychiatric treatment	☐ ☐
Diabetes	☐ ☐	Rheumatic fever	☐ ☐
Epilepsy	☐ ☐	Sinus trouble	☐ ☐
Frequent canker cores	☐ ☐	STDs	☐ ☐
Glaucoma	☐ ☐	Stroke	☐ ☐
Head injury	☐ ☐	Thyroid condition	☐ ☐
Heart disease	☐ ☐	Tuberculosis or lung disease	☐ ☐
Heart murmur	☐ ☐	Tumors or growths	☐ ☐
		Ulcers	☐ ☐

Any other medical problems we need to be aware of: _____
Signature_____ Date ___/___/_____

"I certify that there have been no changes in my health". Please initial and date:
