

## DENTAL HISTORY

Name \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_

Reason for Today's Visit \_\_\_\_\_

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

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

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

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:*

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