DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath	❑ Yes	❑ No
Bleeding gums	❑ Yes	❑ No
Blisters on lips or mouth	❑ Yes	❑ No
Burning sensation on tongue	❑ Yes	❑ No
Chew on one side of mouth	❑ Yes	❑ No
Cigarette, pipe or cigar smoking	❑ Yes	❑ No
Clicking or popping jaw	❑ Yes	❑ No
Dry mouth	❑ Yes	❑ No
Fingernail biting	❑ Yes	❑ No
Food collection between the teeth	❑ Yes	❑ No
Foreign objects	❑ Yes	❑ No
Grinding teeth	❑ Yes	❑ No
Gums swollen or tender	❑ Yes	❑ No
Jaw pain or tiredness	❑ Yes	❑ No
Lip or cheek biting	❑ Yes	❑ No
Loose teeth or broken fillings	❑ Yes	❑ No
Mouth breathing	❑ Yes	❑ No
Mouth pain, brushing	❑ Yes	❑ No
Orthodontic treatment	❑ Yes	❑ No
Pain around ear	❑ Yes	❑ No
Periodontal treatment	❑ Yes	❑ No
Sensitivity to cold	❑ Yes	❑ No
Sensitivity to heat	❑ Yes	❑ No
Sensitivity to sweets	❑ Yes	❑ No
Sensitivity when biting	❑ Yes	❑ No
Sores or growths in your mouth	❑ Yes	❑ No

How often do you floss? _____

How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No
Bleeding abnormally, with extractions or surgery	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No
Circulatory Problems	❑ Yes	❑ No
Congenital Heart Lesions	❑ Yes	❑ No
Cortisone Treatments	❑ Yes	❑ No
Cough, persistent or bloody	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No
Do you wear contact lenses?	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No
Fainting or dizziness	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Headaches	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
Heart Problems	❑ Yes	❑ No
Hepatitis Type _____	❑ Yes	❑ No
Herpes	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
HIV Positive	❑ Yes	❑ No
Jaundice	❑ Yes	❑ No
Jaw Pain	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No
Liver Disease	❑ Yes	❑ No
Low Blood Pressure	❑ Yes	❑ No
Mitral Valve Prolapse	❑ Yes	❑ No
Nervous Problems	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No
Women: Are you pregnant? Due date _____	❑ Yes	❑ No
Are you nursing?	❑ Yes	❑ No
Psychiatric Care	❑ Yes	❑ No
Radiation Treatment	❑ Yes	❑ No
Respiratory Disease	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Scarlet Fever	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
Sinus Trouble	❑ Yes	❑ No
Skin Rash	❑ Yes	❑ No
Special Diet	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
Swelling of Feet or Ankles	❑ Yes	❑ No
Swollen Neck Glands	❑ Yes	❑ No
Thyroid Probems	❑ Yes	❑ No
Tonsillitis	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Tumor or growth on head or neck	❑ Yes	❑ No
Ulcer	❑ Yes	❑ No
Venereal Disease	❑ Yes	❑ No
Weight Loss, unexplained	❑ Yes	❑ No

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin

❑ Barbiturates (Sleeping Pills)

❑ Codeine

❑ Iodine

❑ Latex

❑ Local Anesthetic

❑ Penicillin

❑ Sulfa

❑ Other _____

_____