PATIENT DENTAL AND MEDICAL HISTORY

DENTAL HISTORY

Reason for today's visit: ______________________ Date of last dental visit: ______________________
Former dentist: ______________________ Date of last dental x-rays: ______________________

Please check if you have/had:

- Bad breath ☐
- Blisters on lips or mouth ☐
- Burning sensation on tongue ☐
- Chew on one side of mouth ☐
- Cigarette, pipe, or cigar smoking ☐
- Smokeless tobacco ☐
- Dry mouth ☐
- Food collection between teeth ☐
- Clench teeth ☐
- Grind teeth ☐
- Growths or sore spots in mouth ☐
- Gums swollen, tender, or bleeding ☐
- Head, neck, or jaw pain or aches ☐
- Lip or cheek biting ☐
- Loose teeth or broken fillings ☐
- Mouth breathing ☐
- Orthodontic treatment ☐
- Nitrous Oxide ☐
- Periodontal treatment ☐
- Sensitivity to pressure or irritants (cold, heat, sweets) ☐
- How often do you floss? __________
- How often do you brush? __________

Have you ever had an allergic reactions to Novocaine, local or general anesthetics? ☐
If Yes, please explain:
____

Have you had trouble from previous dental care? ☐
If Yes, please explain what happened:
____
____

MEDICAL HISTORY

Physician's name: ______________________ Date of last visit: __________
Physician's address: ______________________

Have you ever had a blood transfusion? Yes ☐ If Yes, please describe: ______________________

Have you had any serious illnesses or operations? Yes ☐ If Yes, please give approximate dates: ______________________
Pregnant? Yes ☐ Due Date? ______________ Nursing? Yes ☐ Birth Control Pills? Yes ☐

Please check if you have/had:

- Allergies, hay fever, sinusitis ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Asthma: Required Hospitalization ☐
- Asthma: Used Steroids ☐
- Bleeding abnormally with operation/surgery ☐
- Blood Disease, Clotting Disorders ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Circulatory Problems ☐
- Cortisone Treatments ☐
- Cough, persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis? ☐
- Type: ______________
- Herpes ☐
- High Blood Pressure ☐
- Any Immune Deficiency (incl. HIV/AIDS) ☐
- Jaundice ☐
- Kidney Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Osteopenia ☐
- Osteoporosis ☐
- Pacemaker ☐
- Radiation Treatments ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Sickle Cell Anemia ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or Growth on Head/Neck ☐
- Ulcer ☐
- Venereal Disease ☐
- Weight Loss, Unexplained ☐
- Do you wear contact lenses? ☐
- Do you consume alcoholic beverages? ☐
- Are you currently under the care of a Physician? ☐
- Are you allergic/sensitive to Latex? ☐
- Allergic to penicillin, Aspirin or Other Drugs? ☐

If Yes, please specify:
____
____

Are you currently taking any Medications? ☐
If Yes, please list:
____
____
____
____
____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: ______________________ Date: __________
Reviewed by: ______________________ Date: __________