DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for today's visit _____
Former Dentist_____
Address_____

Date of last dental visit _____ How long since your teeth have been cleaned _____

Check (x) if you have had problems with any of the following:

☐ Clicking or popping jaw ☐ Loose teeth or broken fillings ☐ Sensitivity to hot ☐ Grinding teeth
☐ Food collection between teeth ☐ Intraoral sores or bumps ☐ Sensitivity to sweets ☐ Bad breath
☐ Periodontal treatment ☐Sensitivity to cold ☐ Sensitivity to biting ☐ Bleeding gums

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____
Have you had any serious illnesses or operations? ☐ Yes ☐ No If Yes describe_____
Have you ever had a blood transfusion? ☐ Yes ☐ No if Yes ,give approximate dates_____
(**WOMEN)** Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (x) if you have had any of the following:

☐ Anemia ☐ Chemical Dependency ☐ Hepatitis/Jaundice ☐ Stroke
☐ Arthritis, Rheumatism ☐ Chemotherapy ☐ HIV Positive/AIDS ☐ Thyroid Problem
☐ Artificial Heart Valves ☐ Cortisone Treatments ☐ Liver Disease ☐ Tobacco Habit
☐ Artificial Joints ☐ Cough (Persistent) ☐ Mitral Valve Prolapse ☐ Tonsillitis
☐ Asthma/Emphysema ☐ Diabetes/Kidney disease ☐ Pacemaker ☐ Tuberculosis/Lung
☐ Back Problems ☐ Epilepsy/Seizures ☐ Radiation Treatment ☐ Ulcer
☐ Blood Disease ☐ Fainting Spells ☐ Respiratory Disease ☐ Venereal Disease
☐ Blood Pressure (High) ☐ Headaches ☐ Rheumatic Fever ☐ Problems Lying Back
☐ Blood Pressure (Low) ☐ Heart Murmur ☐ Nervous Problems ☐ Latex Allergy
☐ Cancer/ Type: _____ ☐ Heart Problems/Angina ☐ Prolonged Bleeding ☐ Other
☐ Hemophilia ☐ Skin rash

MEDICATIONS

List all current medications:_____
_____
Pharmacy Name and Phone _____

ALLERGIES

☐ Aspirin ☐ Penicillin
☐ Codeine ☐ Sulfa
☐ Local Anesthetic ☐ Other

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____