

DENTAL HEALTH HISTORY (CONFIDENTIAL)

Patient Name _____
Last First Initial

Today's Date _____
Birth Date _____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

MEDICAL HISTORY

Have you had any serious illnesses or operations? Yes No If yes, please describe _____

Have you ever had a blood transfusion? Yes No If yes, please give approximate date(s) _____

Are you currently taking or have you taken Bisphosphonates? Yes No

(Women) Are you pregnant? Yes No Taking birth control pills? Yes No

Check if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Diseases | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | |

MEDICATIONS

List medications you are currently taking:

ALLERGIES

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> 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.

Signature _____

Date _____