Dental History

Reason for Today's Visit:_____
Former Dentist:_____
City/State:_____

Last Dental Cleaning_____
Last Dental X-Ray:_____
X-Rays Taken at any other dental office? ❑ Y ❑ N
If **Yes name of Office**:_____
City/State_____

How often do you brush? ❑ 1x day ❑ 2x day ❑ _____
How often do you floss? ❑ 1x day ❑ 2x day ❑ _____
Do you smoke or use chewing tobacco? ❑ Yes ❑ No ***Are you interested in stopping?*** YES NO SOMEWHAT
Do you have areas where food gets trapped/collects between teeth? ❑ Yes ❑ No
Is there anything you would like to see different about your teeth or that bothers you?_____

Please ✔ if you have had problems with any of the following Dental Issues:

❑ Bad Breath ❑ Bleeding Gums ❑ Blisters on lips/mouth ❑ Clicking /Popping of Jaw ❑ Dry Mouth
❑ Grinding Teeth ❑ Sensitivity to Cold ❑ Sensitive to Heat ❑ Sensitive to Sweets ❑ Canker Sores
❑ Sensitive to biting ❑ Periodontal (gum) Treatment ❑ Orthodontic Treatment ❑ Other_____

MEDICAL HEALTH HISTORY

❑ Y ❑ N **ARTIFICIAL JOINTS**
❑ **Knee** ❑ **Hip** ❑ **Heart Valve** ❑ **Other**_____
Date of replacement:_____
Surgeon:_____
Do you require Pre-Medication before Dental Visits? ❑Y ❑N

❑ Y ❑ N **Congenital Heart Lesions**
❑ Y ❑ N **Stroke** Date:_____
❑ Y ❑ N **Mitral Valve Prolapse**
❑ Y ❑ N **Heart Murmur**
❑ Y ❑ N **Scarlet Fever**
❑ Y ❑ N **Pacemaker**
❑ Y ❑ N **Heart Disease**

❑ Y ❑ N **Anemia**
❑ Y ❑ N **High Blood Pressure**
❑ Y ❑ N **Low Blood Pressure**
❑ Y ❑ N **Hepatitis Type:**_____
❑ Y ❑ N **Diabetes Type:**_____
❑ Y ❑ N **Kidney Disease**
❑ Y ❑ N **Liver Disease**
❑ Y ❑ N **AIDS or HIV**

❑ Y ❑ N **Cancer Type:**_____
❑ Y ❑ N **Radiation/Chemotherapy Treatment**
❑ Y ❑ N **Thyroid Problems**
❑ Y ❑ N **Tuberculosis**
❑ Y ❑ N **Herpes/Cold Sores Frequency**:_____
❑ Y ❑ N **Pregnant Due Date**:_____
❑ Y ❑ N **Alcohol/Chemical Dependency**
❑ Y ❑ N **Abnormal bleeding after extractions or surgery?**

Please note any condition, disease or medical problem not listed?

_____

_____

MEDICATIONS

Please ✔ any medications you are currently taking

☐ **Aspirin**
☐ **Anticoagulants (blood thinners)**
☐ **Antibiotics or sulfa drugs**
☐ **High blood pressure medicine**
☐ **Antidepressants or tranquilizers**
☐ **Insulin, Orinase, or other diabetes drug**
☐ **Nitroglycerin**
☐ **Cortisone or other steroids**
☐ **Osteoporosis (bone density) medicine**
☐ **List All Other Medications:**

_____

_____

_____

ALLERGIES

Please ✔ or list any Allergies to material/medicines

☐ **Penicillin or other Antibiotics** ☐ **Latex**
☐ **Local anesthetics ("Novocain")** ☐ **Sulfa**
☐ **Codeine or other narcotics** ☐ **Aspirin**
☐ **Barbiturates** (sleeping pills)_
☐ **Other Allergies:** _____

Name of Physician:_____
Physician Phone #:_____

Preferred Pharmacy:_____
Pharmacy Phone #:_____

_____
Printed Name of Person Completing form

_____
Signature of Person Completing form **Date**

STOP Please do not write in this area. This is for our Staff to update your Health History on future Dental Visits.

1 Today's Date:_____
Changes to your Health History as noted above? ☐ Y ☐ N

_____
Are you taking any new medications? ☐ Y ☐ N

_____
_____
Signature of Patient **Staff Initials**

2 Today's Date:_____
Changes to your Health History as noted above? ☐ Y ☐ N

_____
Are you taking any new medications? ☐ Y ☐ N

_____
_____
Signature of Patient **Staff Initials**