HEALTH AND DENTAL HISTORY

Personal Physician's Name:_____

Address:_____

Phone Number:_____

What is your current state of Health? __GOOD __FAIR __POOR

List all medications you are taking, including prescriptions, vitamins and suppplements, and over-the counter drugs with dosage and frequency:

_____

_____

_____

Women: Are you pregnant? __YES __NO

Have you been told that you need to take antibiotics before Dental Treatment? __YES __NO If yes, by whom? _____

Have you been hospitalized, had surgery, or any serious medical problems in the past five years? __YES __NO If yes, please explain:

_____

_____

Do you have or have you had any of the following? (check "Yes" or "No"):

Yes	No		Yes	No	
☐	☐	Aids/HIV+/ARC	☐	☐	Anemia
☐	☐	Arthritis	☐	☐	Heart attack/heart disease
☐	☐	Artificial Joint	☐	☐	Cancer
☐	☐	Asthma	☐	☐	Low blood pressure
☐	☐	Blood transfusion	☐	☐	Nervous problems
☐	☐	High blood pressure	☐	☐	Excessive bleeding
☐	☐	Circulatory problems	☐	☐	Herpes
☐	☐	Radiation treatment	☐	☐	Drug/alcohol abuse
☐	☐	Hepatitis Type ____	☐	☐	Diabetes
☐	☐	STD's	☐	☐	Tuberculosis (TB)
☐	☐	Kidney problems	☐	☐	Anorexia/bulemia
☐	☐	Sinus problems	☐	☐	Migraines
☐	☐	Psychiatric problems	☐	☐	Pacemaker/defibrillator
☐	☐	Sickle cell disease	☐	☐	Stroke/TIA's
☐	☐	Thyroid problems	☐	☐	Other (explain below):

_____

_____

_____

Please describe any current medical treatment or condition which may possibly affect your dental treatment: _____

_____

Are you allergic to any of the following? (check "Yes" or "No"):

Yes	No		Yes	No	
☐	☐	Ibuprofen/NSAIDS	☐	☐	Aspirin
☐	☐	Penicillin	☐	☐	Dental (local) anesthetics
☐	☐	Amoxicillin	☐	☐	Codiene/Narcotics
☐	☐	Sulfa	☐	☐	Erythromycin
☐	☐	Latex	☐	☐	Other (explain below):
☐	☐	Erythromycin			

_____

_____

Reason for today's visit:_____

Former Dentist:_____

Date of last dental visit:_____ What was done?_____

_____

Date of last x-rays taken:_____

How often do you visit the dentist?_____

Do you or have you had any of the following? (check "Yes" or "No"):

Yes	No		Yes	No	
☐	☐	Bad breath	☐	☐	Jaw pain or tiredness
☐	☐	Bleaching of your teeth	☐	☐	Lip or cheek biting
			☐	☐	Lip or tongue piercings
☐	☐	Bleeding gums	☐	☐	Loose teeth
☐	☐	Blisters on lips/mouth	☐	☐	Lost fillings/crowns
☐	☐	Burning sensation on tongue	☐	☐	Mouth breathing
			☐	☐	Mouth pain when brushing
☐	☐	Chew on one side of mouth	☐	☐	Orthodontic treatment
			☐	☐	Pain around ear
☐	☐	Cigarette smoker	☐	☐	Periodontal (gum) treatment
☐	☐	Cigar/pipe smoker	☐	☐	Sensitivity to cold
☐	☐	Clicking or popping in jaw joint	☐	☐	Sensitivity to heat
			☐	☐	Sensitivity to sweets
☐	☐	Dry mouth	☐	☐	Sensitivity when chewing
☐	☐	Fingernail biting	☐	☐	Sleep apnea
☐	☐	Food collection between the teeth	☐	☐	Snoring
			☐	☐	Sores or growths in your mouth
☐	☐	Grinding/clenching teeth	☐	☐	Toothache
☐	☐	Gums swollen or tender	☐	☐	Other (explain below):

_____

_____

_____

Please continue on top of next page