DENTAL HEALTH HISTORY

CONFIDENTIAL

Today's Date_____

Patient Name _____ Birthdate _____

DENTAL HISTORY

Reason for Today's Visit_____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays _____

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

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often to you brush?_____ How often do you floss?_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

Have you ever had to take a premedication for dental procedures? ☐ Yes ☒ No Do you have any artificial joints? ☐ Yes ☐ No

Have you ever taken any of the "bisphosphonates" such as Fosamax or Boniva? ☐ Yes ☐ No

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

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Persistent Cough
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☒ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☒ Radiation Treatment
- ☐ Rash
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

☐ None Apply

List any not mentioned: _____

_____

MEDICATIONS

_____

_____

_____

_____

_____

_____

_____

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other _____

_____

_____

SIGNATURE

Signature_____ Date _____

UPDATES

Date	

Renew Health History