

**PLEASE COMPLETE ALL INFORMATION – THANK YOU!**

**PATIENT LAST NAME:** \_\_\_\_\_ **PATIENT FIRST NAME:** \_\_\_\_\_

**DENTAL HISTORY**

Reason for today's visit: \_\_\_\_\_ Date of last dental visit: \_\_\_\_\_  
Former dentist: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

**Please check if you have/had:**

- |                                   |                          |                                      |                          |  |                          |
|-----------------------------------|--------------------------|--------------------------------------|--------------------------|--|--------------------------|
| Bad breath                        | <input type="checkbox"/> | Gums swollen, tender, or bleeding    | <input type="checkbox"/> | Have you ever had an allergic reactions      | <input type="checkbox"/> |
| Blisters on lips or mouth         | <input type="checkbox"/> | Head, neck, or jaw pain or aches     | <input type="checkbox"/> | to Novocaine, local or general anesthetics?  |                          |
| Burning sensation on tongue       | <input type="checkbox"/> | Lip or cheek biting                  | <input type="checkbox"/> | <i>If Yes, please explain:</i>               | _____                    |
| Chew on one side of mouth         | <input type="checkbox"/> | Loose teeth or broken fillings       | <input type="checkbox"/> |  |                          |
| Cigarette, pipe, or cigar smoking | <input type="checkbox"/> | Mouth breathing                      | <input type="checkbox"/> | Have you had trouble from previous           | <input type="checkbox"/> |
| Smokeless tobacco                 | <input type="checkbox"/> | Orthodontic treatment                | <input type="checkbox"/> | dental care?                                 |                          |
| Dry mouth                         | <input type="checkbox"/> | Nitrous Oxide                        | <input type="checkbox"/> | <i>If Yes, please explain what happened:</i> | _____                    |
| Food collection between teeth     | <input type="checkbox"/> | Periodontal treatment                | <input type="checkbox"/> |  |                          |
| Clench teeth                      | <input type="checkbox"/> | Sensitivity to pressure or irritants | <input type="checkbox"/> |  |                          |
| Grind teeth                       | <input type="checkbox"/> | (cold, heat, sweets)                 |                          |  |                          |
| Growths or sore spots in mouth    | <input type="checkbox"/> | How often do you floss? _____        |                          |  |                          |
|                                   |                          | How often do you brush? _____        |                          |  |                          |

**MEDICAL HISTORY**

Physician's name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
Physician's address: \_\_\_\_\_

Have you ever had a blood transfusion? Yes  If Yes, please describe: \_\_\_\_\_

Have you had any serious illnesses or operations? Yes  If Yes, please give approximate dates: \_\_\_\_\_

Pregnant? Yes  Due Date? \_\_\_\_\_ Nursing? Yes  Birth Control Pills? Yes

**Please check if you have/had:**

- |  |                          |  |                          |   |                          |
|--|--------------------------|--|--------------------------|---|--------------------------|
| Allergies, hay fever, sinusitis            | <input type="checkbox"/> | Heart Problems                         | <input type="checkbox"/> | Thyroid Problems                                | <input type="checkbox"/> |
| Anemia                                     | <input type="checkbox"/> | Hepatitis?                             | <input type="checkbox"/> | Tonsillitis                                     | <input type="checkbox"/> |
| Arthritis, Rheumatism                      | <input type="checkbox"/> | Type: _____                            |                          | Tuberculosis                                    | <input type="checkbox"/> |
| Artificial Heart Valves                    | <input type="checkbox"/> | Herpes                                 | <input type="checkbox"/> | Tumor or Growth on Head/Neck                    | <input type="checkbox"/> |
| Artificial Joints                          | <input type="checkbox"/> | High Blood Pressure                    | <input type="checkbox"/> | Ulcer   | <input type="checkbox"/> |
| Asthma                                     | <input type="checkbox"/> | Any Immune Deficiency (incl. HIV/AIDS) | <input type="checkbox"/> | Venereal Disease                                | <input type="checkbox"/> |
| Asthma: Required Hospitalization           | <input type="checkbox"/> | Jaundice                               | <input type="checkbox"/> | Weight Loss, Unexplained                        | <input type="checkbox"/> |
| Asthma: Used Steroids                      | <input type="checkbox"/> | Kidney Disease                         | <input type="checkbox"/> | Do you wear contact lenses?                     | <input type="checkbox"/> |
| Bleeding abnormally with operation/surgery | <input type="checkbox"/> | Low Blood Pressure                     | <input type="checkbox"/> | Do you consume alcoholic beverages?             | <input type="checkbox"/> |
| Blood Disease, Clotting Disorders          | <input type="checkbox"/> | Mitral Valve Prolapse                  | <input type="checkbox"/> | Are you currently under the care of a           | <input type="checkbox"/> |
| Cancer                                     | <input type="checkbox"/> | Osteopenia                             | <input type="checkbox"/> | Physician?                                      |                          |
| Chemical Dependency                        | <input type="checkbox"/> | Osteoporosis                           | <input type="checkbox"/> | Are you allergic/sensitive to Latex?            | <input type="checkbox"/> |
| Chemotherapy                               | <input type="checkbox"/> | Pacemaker                              | <input type="checkbox"/> | Allergic to penicillin, Aspirin or Other Drugs? | <input type="checkbox"/> |
| Circulatory Problems                       | <input type="checkbox"/> | Radiation Treatments                   | <input type="checkbox"/> | <i>If Yes, please specify:</i>                  | _____                    |
| Cortisone Treatments                       | <input type="checkbox"/> | Respiratory Disease                    | <input type="checkbox"/> |   |                          |
| Cough, persistent or bloody                | <input type="checkbox"/> | Rheumatic Fever                        | <input type="checkbox"/> |   |                          |
| Diabetes                                   | <input type="checkbox"/> | Scarlet Fever                          | <input type="checkbox"/> | Are you currently taking any Medications?       | <input type="checkbox"/> |
| Emphysema                                  | <input type="checkbox"/> | Shortness of Breath                    | <input type="checkbox"/> | <i>If Yes, please list:</i>                     | _____                    |
| Epilepsy                                   | <input type="checkbox"/> | Sinus Trouble                          | <input type="checkbox"/> |   |                          |
| Fainting                                   | <input type="checkbox"/> | Sickle Cell Anemia                     | <input type="checkbox"/> |   |                          |
| Glaucoma                                   | <input type="checkbox"/> | Skin Rash                              | <input type="checkbox"/> |   |                          |
| Headaches                                  | <input type="checkbox"/> | Stroke                                 | <input type="checkbox"/> |   |                          |
| Heart Murmur                               | <input type="checkbox"/> | Swelling of Feet/Ankles                | <input type="checkbox"/> |   |                          |

**AUTHORIZATION AND RELEASE**

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_