Dental History

Former Dentist ______________________________

City, State ______________________________

Date of Las Dental Visit ______________________________

Date of Last X-Rays ______________________________

How Often Do You Floss? ______________________________

How Often Do You Brush? ______________________________

Please check all that apply:

- ☐ Bad Breath
- ☐ Loose Teeth or Broken Fillings
- ☐ Sensitivity to Sweets
- ☐ Bleeding Gums
- ☐ Orthodontic Treatment
- ☐ Jaw, Head or Neck Injuries
- ☐ Sensitivity When Biting
- ☐ Blisters on Lips or Mouth
- ☐ Pain around Ear
- ☐ Frequent Headaches
- ☐ Finger Nail Biting
- ☐ Periodontal Treatment
- ☐ Grinding Teeth
- ☐ Sensitivity to Cold
- ☐ Jaw Difficulty: Clicking and/or Pain
- ☐ Lip or Cheek Biting
- ☐ Sensitivity to Heat
- ☐ Tooth Pain

Medical History

Physician's Name ______________________________

Date of Last Visit ______________________________

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐

Please describe: ______________________________

____

	Yes	No
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

	Yes	No
Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally with extractions or surgery
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chronic Fatigue Syndrome
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough - persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis-Type
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Latex Sensitivity
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head/neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Others ______________________________

Print Name ______________________________

Signature of Responsible Party ______________________________ Date ______________________________