NAME:

DENTAL HISTORY

ORAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

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

How often do you brush? Floss?

How do you feel about the appearance of your teeth?

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

☐ Y ☐ N

Other information about your dental health or previous treatment

MEDICAL HISTORY

☐ Y ☐ N	Under a physician's care now?	Primary Care Physicians Name & Phone Number:
	If yes please describe:	
☐ Y ☐ N	Have you ever had a blood transfusion?	If yes please provide dates:
☐ Y ☐ N	Any serious illnesses/surgeries?	If yes please describe:
☐ Y ☐ N	Have you even taken Fen-Phen / Redux?	

FEMALE PATIENTS:	☐ Y ☐ N Currently nursing?	☐ Y ☐ N Currently pregnant?	☐ Y ☐ N Taking birth control pills

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ **NONE**

☐ AIDS/HIV	☐ CORTISONE TREATMENTS	☐ HIGH BLOOD PRESSURE	☐ SKIN RASH
☐ ANAPHYLAXIS	☐ COUGH, PERSISTENT	☐ JAW PAIN	☐ SPINA BIFIDA
☐ ANEMIA	☐ COUGH UP BLOOD	☐ KIDNEY DISEASE	☐ STROKE
☐ ARTHRITIS, RHEUMATISM	☐ DIABETES	☐ LIVER DISEASE	☐ SURGICAL IMPLANT
☐ ARTIFICIAL HEART VALVE	☐ EPILEPSY	☐ MITRAL VALVE PROLAPSE	☐ SWELLING OF FEET /ANKLES
☐ ARTIFICIAL JOINTS	☐ FAINTING	☐ NERVOUS PROBLEMS	☐ THYROID DISEASE
☐ ASTHMA	☐ FOOD ALLERGIES	☐ PACEMAKER / HEART SURGERY	☐ TOBACCO HABIT
☐ ATOPIC (ALLERGY PRONE)	☐ GLAUCOMA	☐ PSYCHIATRIC CARE	☐ TONSILLITIS
☐ BACK PROBLEMS	☐ HEADACHES	☐ RAPID WEIGHT LOSS OR GAIN	☐ TUBERCULOSIS
☐ BLOOD DISEASE	☐ HEART MURMUR	☐ RADIATION TREATMENT	☐ ULCER/COLITIS
☐ CANCER/MALIGNANCY	☐ HEART PROBLEMS	☐ RESPIRATORY DISEASE	☐ VENERAL DISEASE
☐ CHEMICAL DEPENDENCY	☐ HEMOPHILLIA	☐ RHEUMATIO / SCARLET FEVER	☐ OTHER_____
☐ CHEMOTHERAPY/RADIATION	☐ HERPES	☐ SHINGLES	
☐ CIRCULATORY PROBLEMS	☐ HEPATITIS	☐ SHORTNESS OF BREATH	

DO YOU HAVE ANY DRUG ALLERGIES? IF YES, LIST ALL ☐ NONE

DO YOU HAVE ANY MATERIAL ALLERGIES? (CHECK ALL THAT APPLY): ☐ NONE

☐ LATEX	☐ WOOL	☐ METAL SENSITIVITY	☐ CHEMICALS

MEDICATION INFORMATION

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? IF YES, LIST ALL ☐ NONE

AUTHORIZATION

I HAVE REVIEWED THE INFORMATION ON THIS QUESTIONNAIRE, AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE USED BY THE DENTIST TO HELP DETERMINE APPROPRIATE AND HEALTHFUL DENTAL TREATMENT. IF THERE IS ANY CHANGE IN MY MEDICAL STATUS, I WILL INFORM THE DENTIST.

SIGNATURE: _____ DATE: _____