Dental History

Reason for today's visit _____

_____

Former Dentist _____

Last dental visit _____

Check all that apply

Would you like whiter teeth?	□ Yes	□ No
Bad breath	□ Yes	□ No
Bleeding gums	□ Yes	□ No
Blisters on lips or mouth	□ Yes	□ No
Burning sensation on tongue	□ Yes	□ No
Chew on one side of mouth	□ Yes	□ No
Cigarette, pipe, E-cig, or cigar smoking	□ Yes	□ No
Clicking or popping jaw	□ Yes	□ No
Dry mouth	□ Yes	□ No
Fingernail biting	□ Yes	□ No
Food collection between teeth	□ Yes	□ No
Foreign objects	□ Yes	□ No
Grinding teeth	□ Yes	□ No
Gums swollen or tender	□ Yes	□ No
Jaw Pain or tiredness	□ Yes	□ No
Lip or Cheek biting	□ Yes	□ No
Loose teeth or broken fillings	□ Yes	□ No
Mouth breathing	□ Yes	□ No
Mouth pain, brushing	□ Yes	□ No
Orthodontic treatment	□ Yes	□ No
Pain around ear	□ Yes	□ No
Periodontal treatment	□ Yes	□ No
Sensitivity to cold	□ Yes	□ No
Sensitivity to heat	□ Yes	□ No
Sensitivity to sweets	□ Yes	□ No
Sores or growths in mouth	□ Yes	□ No

How often do you floss? _____x/a day

How often do you brush? _____x/a day

Medical History

Physician's Name _____ Date of last visit _____

Check all that apply

AIDS	□ Yes	□ No	Emphysema	□ Yes	□ No	Psychiatric Care	□ Yes	□ No
Alzheimer's	□ Yes	□ No	Epilepsy	□ Yes	□ No	Radiation Treatment	□ Yes	□ No
Anemia	□ Yes	□ No	Fainting/dizzy	□ Yes	□ No	Respiratory Disease	□ Yes	□ No
Arthritis	□ Yes	□ No	Glaucoma	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No
Artificial heart valves	□ Yes	□ No	Headaches	□ Yes	□ No	Scarlet Fever	□ Yes	□ No
Artificial Joints	□ Yes	□ No	Heart Murmur	□ Yes	□ No	Shortness of Breath	□ Yes	□ No
Asthma	□ Yes	□ No	Heart Problems	□ Yes	□ No	Sinus Trouble	□ Yes	□ No
Back problems	□ Yes	□ No	Hepatitis (Type____)	□ Yes	□ No	Skin Rash	□ Yes	□ No
Bleeding abnormally w/ extraction or surgery	□ Yes	□ No	Herpes	□ Yes	□ No	Special Diet	□ Yes	□ No
			High Blood Pressure	□ Yes	□ No	Stroke	□ Yes	□ No
Blood Disease	□ Yes	□ No	HIV Positive	□ Yes	□ No	Swelling of feet or ankle	□ Yes	□ No
Cancer	□ Yes	□ No	Jaundice	□ Yes	□ No	Swollen Neck Glands	□ Yes	□ No
Chemical Dependency	□ Yes	□ No	Jaw Pain	□ Yes	□ No	Thyroid Problems	□ Yes	□ No
Circulatory Problems	□ Yes	□ No	Kidney Disease	□ Yes	□ No	Tonsillitis	□ Yes	□ No

Medications

List medications you are currently taking

_____

_____

Pharmacy Name _____

Phone Number (____) _____

Allergies

□ Aspirin □ Penicillin

□ Barbiturates (sleeping pills) □ Sulfa

□ Codeine □ Other _____

□ Iodine _____

□ Latex _____

□ Local Anesthetic

***Signature of Patient»** _____