Dental/Medical Health History

Confidental

Today's Date_____

Patient Name_____
Last First Middle Initial

Dental History

Reason For Today's Visit_____

Preferred Dentist/Office_____

Date of Last Dental Visit_____

Check if you have had the following:

❑ Bad Breath ❑ Bleeding Gums ❑ Clicking or popping jaw ❑ Food collection between teeth ❑ Grinding teeth ❑ Loose teeth or broken filings	❑ Periodontal treatment ❑ Sensitivity to cold ❑ Sensitivity to hot ❑ Sensitivity to sweets ❑ Sensitivity when biting ❑ Sores or growths in your mouth

How often do you brush?_____

How often do you floss?_____

Medical History

Physician's Name_____ Date of Last Visit_____

List any serious operations or illnesses:

_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____

Have you had a blood transfusion? YES NO
If yes, approx dates_____

Check if you have had the following:

❑ Anemia ❑ Arthritis ❑ Artificial Heart Valves ❑ Artificial Joints ❑ Asthma ❑ Back Pain ❑ Blood Disease ❑ Cancer ❑ Chemical Dependency ❑ Chemotherapy ❑ Circulatory Problems ❑ Cortisone Treatments ❑ Cough, Persistent ❑ Cough up Blood ❑ Diabetes 1 2 ❑ 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 ❑ Respiratory Disease ❑ Rheumatic Fever ❑ Scarlet Fever ❑ Shortness of Breath ❑ Skin Rash ❑ Stroke ❑ Swelling of Feet or Ankles ❑ Thyroid Problems ❑ Tobacco Habit ❑ Tonsillitis ❑ Tuberculosis ❑ Ulcer ❑ Venereal Disease

Medications

List Medications you are currently taking: _____ _____ _____ Pharmacy Name_____ Phone:_____	**Allergies:** ❑ Aspirin ❑ Barbiturates (Sleeping Pills) ❑ Codeine ❑ Local Anesthetic ❑ Penicillin ❑ Sulfa ❑ Latex ❑ Other_____

Signature

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the office of any changes in health.

_____

Signature of Patient or Personal Representative Date

_____

Printed Name Relationship to Patient