5. Dental History

Referred by _____ Previous Dentist _____ How Long _____

Most Recent Dental Exam _____ Most Recent Dental X-Ray _____ Most Recent Dental Treatment _____

How often do you have your teeth cleaned? 3 mo. _____ 4 mo. _____ 6 mo. _____ 1 year or longer _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO		YES	NO
unhappy with the appearance of your teeth	☐	☐	jaw problems (temporomandibular joint)	☐	☐
problems with effectiveness or bad reactions to dental anesthetic	☐	☐	clench or grind your teeth	☐	☐
orthodontic treatment (braces), when:_____	☐	☐	lost any teeth	☐	☐
periodontal (gum) treatment, when:_____	☐	☐	sore teeth	☐	☐
bleeding gums	☐	☐			

6. Medical History

HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO		YES	NO
hospitalization for illness or injury, year:_____	☐	☐	kidney disease	☐	☐
allergic reaction to:			liver disease, hepatitis (type_____)	☐	☐
☐ aspirin, ibuprofen, acetomenophen ☐ sulfa			jaundice	☐	☐
☐ penicillin ☐ latex			thyroid or parathyroid disease	☐	☐
☐ erythromycin ☐ local anesthetic			arthritis	☐	☐
☐ tetracycline ☐ fluoride			glaucoma	☐	☐
☐ codeine ☐ any other medications			contact lenses	☐	☐
☐ metals (gold) stainless steel ☐ _____			head or neck injuries	☐	☐
cancer, type:_____	☐	☐	epilepsy, convulsions (seizures)	☐	☐
heart problems	☐	☐	asthma	☐	☐
heart murmur	☐	☐	a heavy smoker (1 pack or more a day)	☐	☐
rheumatic fever	☐	☐	HIV / AIDS	☐	☐
scarlet fever	☐	☐	diabetes	☐	☐
high blood pressure	☐	☐	stomach or duodenal ulcer	☐	☐
low blood pressure	☐	☐	often exhausted or fatigued	☐	☐
a stroke	☐	☐	venereal disease	☐	☐
artificial prosthesis (i.e. heart valve, hip, knee)	☐	☐	radiation therapy	☐	☐
anemia or other blood disorder	☐	☐	FEMALE - taking birth control pills	☐	☐
emphysema	☐	☐	FEMALE - pregnant	☐	☐
chemotherapy	☐	☐	MALE - Prostate disorders	☐	☐

MEDICATIONS:

List any medication you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____ Phone (_____) _____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____