

# DENTAL HEALTH HISTORY

## Confidential

Today's Date: \_\_\_\_\_

Patient Name \_\_\_\_\_

Birthdate: \_\_\_\_\_

### DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

Check (√) if you have had problems with any of the following:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot        |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets     |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting   |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

### MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you had any serious operations? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate date \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin, Pondimin and Redux.  Yes  No

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (√) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Scarlet Fever        |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of breath  |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up blood       | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Skin Rash            |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain            | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Swelling-Feet/Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Endocarditis        | <input type="checkbox"/> Tobacco Habit        |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Tonsillitis          |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer                |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Venereal Disease     |

### MEDICATIONS

List medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone \_\_\_\_\_

### ALLERGIES

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> Aspirin          | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates     | <input type="checkbox"/> Sulfa      |
| <input type="checkbox"/> Codeine          | <input type="checkbox"/> Latex      |
| <input type="checkbox"/> Local anesthetic | <input type="checkbox"/> Other      |

### SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian

Date