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:

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

How often do you floss?_____How often do you brush?_____

MEDICAL HISTORY

Physician's Name_____Phone#_____ 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 "bisphosphonates?" (used to treat osteoporosis)? These include but are not limited to (oral) Actonel, Atelvia, Boniva, Didronel, Fosamax, Skelid, **OR** (injectable) Aredia,Bonefos, Reclast, Zometa □ 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:

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

MEDICATIONS

List medications you are currently taking:_____

_____

_____

Pharmacy Name_____

Phone_____

ALLERGIES/SENSITIVITIES

□ Aspirin	□ Penicillin
□ Metals/Jewelry	□ Sulfa
□ Codeine	□ Latex
□ Local Anesthetic	□ 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