Dental & Medical Health History
Please complete ***all*** information

First Name:_____ Last Name:_____
Reason for visit:_____
Former Dentist:_____
Date of last dental visit:_____ Date of last dental X-rays:_____
Do you like your smile? YES NO
If no, what's your biggest concern:_____

Dental History
Please check if you have/had any of the following:

_____Bad Breath
_____Blisters on lip or mouth
_____Burning sensation on tongue
_____Chew on one side of mouth
_____Smoke cigarette, pipe or cigars
Amount per day_____
_____Smokeless tobacco
Amount per day_____
_____Dry mouth/mouth breath
_____Food collection between teeth
_____Clench or grind teeth
_____Growth or sore spots
_____Gum swollen/tender/bleeding
_____Head/neck/jaw pain or aches
_____Lip or cheek biting
_____Loose teeth or broken fillings
_____Orthodontic (Braces) treatment
_____Nitrous Oxide
_____Periodontal (Gum) treatment
_____Sensitivity to pressure or irritants
How often do you floss?_____
How often do you brush?_____

Have you ever had an allergic reaction to Novocaine (Lidocaine) local or general anesthetics? YES NO
If yes, please explain:_____
Have you ever had trouble from previous dental care? YES NO
If yes, please explain:_____

Medical History
Physician's name:_____ Date of last visit:_____
Physician's address:_____
Have you had any serious illnesses or operations? YES NO
If yes, please describe:_____
Women Are you pregnant? YES NO If yes due date: / / 20
Are you nursing? YES NO Take birth control pills? YES NO

Please check if you have/had any of the following:

_____AIDS/HIV
_____Allergies/hay fever/Sinusitis
_____Anemia
_____Arthritis
Explain_____
_____Artificial heart valves
Date_____
_____Artificial joints
_____Asthma
_____Required hospitalization/use steroids
Last episode_____
_____Bleeding abnormally (surgery)
_____Blood disease/clotting disorders
Explain_____
_____Take blood thinners
Explain_____
_____Blood transfusion
Dates_____
_____Cancer
Dates_____
_____Chemical dependency
Explain_____

_____Chemotherapy
Date_____
_____Circulatory problems
_____Wear contact lenses
_____Consumes alcoholic beverages
_____Cortisone treatments
_____Cough, persistent/bloody
_____Diabetes Type: I or II
_____Emphysema
_____Epilepsy
Last episode_____
_____Fainting
Last episode_____
_____Glaucoma
_____Head/neck tumors
Explain_____
_____High blood pressure
_____Headaches
_____Heart murmur
Last diagnosed_____
_____Heart problems
Explain_____
_____Hepatitis
Type_____
_____Herpes
Type_____
_____Immune deficiency
_____Jaundice
_____Kidney disease
_____Low blood pressure
_____Medicinal Marijuana
_____Mitral valve prolapse
Last diagnosed_____
_____Osteoporosis
_____Pacemaker
Date_____
_____Radiation therapy
Date_____
_____Respiratory disease
_____Rheumatic fever
_____Scarlet fever
_____Skin rash
_____Shortness of breath
_____Sickle cell anemia
_____Sinus trouble
_____Slow healing wounds
_____Stroke
Date_____
_____Swelling of feet/ankles
_____Thyroid problems
Explain_____
_____Tonsillitis
_____Tuberculosis
Last positive test_____
_____Ulcer
_____Venereal disease
_____Weight loss, unexplained

Are you currently under the care of a physician? YES NO
Are you allergic to **latex/penicillin/aspirin/other?**

List ***all*** *prescription medications* and *OTC Medications* you are currently taking:

Authorization & Release
I have read and answered the above questions to the best of my knowledge
Patient / Legal Guardian Signature **Date: / / 20**

Reviewed by staff member **Date: / / 20**