Dental & Medical Health History

For office staff only
Date:___/___/20__
BP:___/___ P:____

First Name: ______________________________ Last Name: _______________________________
Reason for visit: ____
Former Dentist: _______________________________ 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 cigarettes, 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
_____ Gums 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: ______ / ______/ ________
Are you nursing? YES NO Take birth control pills? YES NO

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

__Aids/HIV
__Artificial heart valve
__Blood disease/clotting disorder
__Cancer
__Wear contact lenses
__Diabetes Type I or II
__High blood pressure
__Hepatitis
__Low blood pressure
__Radiation therapy
__Sickle Cell anemia
__Swelling of feet/ankles
__Ulcer
__Allergies/hay fever/Sinusitis
__Artificial joints
__Chemical Dependency
__Consume alcoholic beverages
__Emphysema
__Headaches
__Immune deficiency
__Mitral valve prolapse
__Rheumatic fever
__Sinus trouble
__Thyroid Problems
__Weight loss, unexplained
__Anemia
__Asthma
__Take blood thinners
__Chemotherapy
__Cortisone treatment
__Fainting
__Heart murmur
__Jaundice
__Osteoporosis
__Skin rash
__Slow Healing wounds
__Tonsillitis
__Arthritis
__Bleeding abnormally(surgery)
__Blood transfusion
__Circulatory problems
__Cough
__Glaucoma
__Heart problems
__Kidney disease
__Pacemaker
__Shortness of breath
__Stroke
__Tuberculosis

Are you currently under the care of a physician? YES NO
Are you allergic to **latex/penicillin/aspirin/Aspirin/any metals/barbiturates/sulfa drugs/other**?
List all prescription medications and OTC Medications you are currently taking:

Authorizations & Release

I have read and answered the above questions to the best of my knowledge

Patient / Legal Guardian Signature **Date: / /**

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