Patient Name____ date______________

Dental History

circle one

yes no Do you have a specific dental problem? Describe____
yes no Do you have dental examinations on a regular basis? When was your last visit?______________________
yes no Do you think you have any active decay or gum disease?____________________________________
yes no Do you brush and floss on a regular basis? How often?_____________________________________
yes no Do your gums ever bleed? When?____
yes no Do you like your smile? Why/why not?____
yes no Does food catch between your teeth? Where? (upper, lower, left and/or right)_________________________
yes no Do you have any loose teeth? Where? (upper,lower,left and/or right)______________________________
yes no Do you want to keep your remaining teeth? If no, explain_____________________________________
yes no Do you have discomfort in your jaw joint?_______ Do you have clicking or popping in your jaw joints? __________
yes no Do you brux or grind your teeth?____
yes no Do you use tobacco products?____
yes no Do you have any sores or growths in your mouth? Discuss.______________________________________
yes no Have your past experiences at the dentist always been positive? ______________________________
yes no Name of your previous dentist ________________________ phone number______________________
yes no Date of last check up xrays?__________Date of last Full Mouth xrays or panorex?_____________

Medical History

Are you currently under a physician's care? yes no If 'yes', why? _______________________________
name of your physician?______________________________phone number______________________
Have you ever been hospitalized? Any major surgery? Please discuss._______________________________
Have you ever had an injury to your head or neck? Discuss___________________________________
Are you taking any medications? List the names and doses___________________________________
____
Have you ever taken bisphosphonate medication? For how long? Are you still? ____________________________
Are you on any special diet? Explain____
Are you allergic to any medications of substances? Please circle below:
Aspirin Penicillin Latex Codeine Acrylic Other__________________________
Women: are you pregnant or trying to become pregnant? ________ Nursing?________ Taking contraceptives?____________
Please check yes or no to each of the following:

y n Heart Disease	y n Bruise easily	y n Emphysema	y n Jaundice	y n cold sores
y n Heart murmur	y n Anemia	y n Tuberculosis	y n Kidney problems	y n fever blisters
y n Irregular heart beat	y n Excessive bleeding	y n Cancer	y n Dialysis	y n Herpes
y n Angina/chest pain	y n Sickle cell disease	y n Radiation Treatments	y n Thyroid Disease	y n Stroke
y n Heart Attack/Failure	y n Hemophilia	y n Chemotherapy	y n Parathyroid Disease	y n Convulsions
y n Congenital Heart Disorder	y n Leukemia	y n stomach problems	y n intestinal problems	y n Arthritis
y n Mitral Valve Prolapse	y n Epilepsy/Seizures	y n Recent blood transfusion	y n Ulcers	y n Rheumatism
y n Fainting/Dizziness	y n Scarlet Fever	y n Swelling of Limbs	y n Recent Weight Loss	y n Joint Pain
y n Glaucoma	y n Rheumatic Fever	y n Lund Disease	y n Frequent Diarrhea	y n Cortisone Medication
y n Tumors/Growths	y n Replaced Heart Valve	y n Breathing Problem	y n Diabetes	y n Artificial Joint
y n Nervousness	y n Pace Maker	y n Excessive Thirst	y n Venereal Disease	y n Psychiatric care
y n Heart Surgery	y n Frequent Cough	y n Hypoglycemia	y n HIV Positive	y n Dementia
y n High Blood Pressure	y n Hay Fever	y n Liver Disease	y n Allergy (medications)	y n Low Blood Pressure
y n Sinus Problems	y n Hepatitis A (infectious)	y n Genital Herpes	y n Allergy (pollen)	y n Blood Disease
y n Asthma	y n Hepatitis B (Serum)	y n Drug Addiction	y n Hives/Rash	y n Use tobacco products

Have you ever had any serious illness not checked above? y n If yes, discuss ______________________________________
Do you wish to talk to the dentist privately about any problem? y n
To the best of my knowledge all of the above answers are correct. If there are any changes in my health status or if my medications change I will inform the dentist at my next appointment.

patient signature_____________________________ date__________ DDS signature____________________________date__________