

DENTAL/ HEALTH HISTORY

Date _____ Patient Name _____ Birthdate _____

DENTAL HISTORY			
Reason for Today's Visit _____ _____ Former Dentist _____ City/State _____ Date of last dental visit _____ Date of last dental X-rays _____ Place a mark on "Yes" or "No" to indicate If you have had any of the following: Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Cigarette, pipe, or Cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No Clicking or popping Jaw <input type="checkbox"/> Yes <input type="checkbox"/> No Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No Jaw Pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing Mouth pain, brushing Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No Sores or growths in Your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No How often do you floss? _____ How often do you brush? _____	

HEALTH HISTORY	
Physician's Name _____	Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with Extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet / Ankle	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor /growth on Head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent / bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, Unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Women:

Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Due date _____	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Taking birth control pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

MEDICATIONS	ALLERGIES		
List Any medications you're currently taking & Reason:	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Penicillin
	<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Iodine
	<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex	<input type="checkbox"/> Other _____