

## Dental History

Patient's Name: \_\_\_\_\_ Prefer to be called: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Former Dentist: \_\_\_\_\_ Location (City): \_\_\_\_\_

Date of last dental care: \_\_\_\_\_ Date of last x-rays: \_\_\_\_\_

Check if you have had problems with any of the following:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Bad breath              | <input type="checkbox"/> Food collection between teeth  | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity to sweets     |
| <input type="checkbox"/> Bleeding gums           | <input type="checkbox"/> Grinding or clenching teeth    | <input type="checkbox"/> Sensitivity to cold   | <input type="checkbox"/> Sensitivity when biting   |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to hot    | <input type="checkbox"/> Sores or growths in mouth |

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

If you could make a change to your teeth, what would it be? \_\_\_\_\_

Have you ever experienced an adverse reaction during a medical or dental procedure?  Y  N

Other information about your dental health or previous treatment \_\_\_\_\_

## Medical History

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations?  Y  N

If yes, describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Women: Are you pregnant?  Y  N Nursing?  Y  N Taking birth control pills?  Y  N

Check if you have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Acid Reflux             | <input type="checkbox"/> Chemical/Drug dependency | <input type="checkbox"/> Hemophilia or abnormal bleeding                         | <input type="checkbox"/> Radiation treatment        |
| <input type="checkbox"/> ADD/ADHD                | <input type="checkbox"/> Chemotherapy             | <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Respiratory disease        |
| <input type="checkbox"/> AIDS/HIV                | <input type="checkbox"/> Circulatory problems     | <input type="checkbox"/> High blood pressure                                     | <input type="checkbox"/> Rheumatic/Scarlet fever    |
| <input type="checkbox"/> Alzheimer's             | <input type="checkbox"/> Cortisone treatments     | <input type="checkbox"/> Kidney disease/malfunction                              | <input type="checkbox"/> Shortness of breath        |
| <input type="checkbox"/> Anaphylaxis             | <input type="checkbox"/> Cough, persistent        | <input type="checkbox"/> Liver disease   | <input type="checkbox"/> Sinus Infections           |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough up blood           | <input type="checkbox"/> Material allergies (latex, wool, metal, chemicals, etc) | <input type="checkbox"/> Skin rash                  |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Mitral valve prolapse                                   | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Eating disorder          | <input type="checkbox"/> Nervous problems  | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Artificial joints       | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Osteoporosis/osteopenia                                 | <input type="checkbox"/> Thyroid problems           |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Pacemaker/Heart surgery                                 | <input type="checkbox"/> Tobacco habit: _____       |
| <input type="checkbox"/> Autism                  | <input type="checkbox"/> Food allergies           | <input type="checkbox"/> Psychiatric care  | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Back problems           | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Rapid weight loss/gain                                  | <input type="checkbox"/> Ulcer or Colitis           |
| <input type="checkbox"/> Blood disease           | <input type="checkbox"/> Have taken Phen-Fen      | <input type="checkbox"/> Heart problems-describe: _____                          | <input type="checkbox"/> Venereal disease           |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Alcoholic beverages per week _____                      |   |
| <input type="checkbox"/> Chemical imbalance      | <input type="checkbox"/> Heart murmur             |  |   |

List any medications or drugs you currently are taking: \_\_\_\_\_

List any drug allergies: \_\_\_\_\_

## Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. If there is any change in my medical status, I will inform the dentist.

I authorize the use of anesthetics during the course of treatment knowing that adverse reactions may occur such as but not limited to prolonged or permanent numbness, increased heart rate, swelling, soreness, etc.

I authorize the use of photographs before, during, and after treatment to be used in diagnosis, communications with labs and insurance companies and other doctors, and for marketing or display purposes when my name is not identified with photos.

Patient (or Parent/Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_