Dental Health History

Patient Name: ____ Date of Birth: ________________________

Reason for today's visit: ______________________________________ Date of last dental visit: _____________________

Please circle if you have had problems with any of the following:

Bad Breath   Bleeding Gums   Clicking/Popping of Jaw   Grinding teeth   Sores/growths in mouth

Food collection between teeth   Periodontal treatment   Loose teeth or broken fillings

Sensitivity to cold   Sensitivity to hot   Sensitivity to sweets   Sensitivity with biting

Medical History

Physician's Name: ____ Phone : ______________________________

ALLERGIES: Are you allergic or have you reacted adversely to any of the following (check all that apply):

___ Aspirin
___ Codeine
___ Nitrous Oxide
___ Penicillin
___ Erythromycin
___ Local Anesthesia (Novocaine)

__ Ibuprofen
__ Sulfa Drugs, Sulfites, Sulfides
__ Acetaminophen/Tylenol
__ Barbiturates
__ Tetracycline
__ Latex, Metals, Plastic

Please list any additional allergies: ____

HEALTH CONDITIONS: Check any of the following that you have had or have at the present:

___ Osteoporosis
___ Heart disease or heart attack
___ Abnormal blood pressure
___ Heart murmur/mitral valve prolapse
___ Rheumatic fever
___ Heart pacemaker
___ Heart surgery
___ Stroke
___ Kidney disease
___ History of drug addiction /alchoholism
___ Arthritis
___ Anemia
___ Bleeding disorders
___ Hay fever
___ Ulcers
___ Jaundice
___ Herpes / cold sores
___ Tumor or malignancy
___ Radiation treatment
___ Anaphylaxis
___ Headaches

__ Bisphosphonate therapy (e.g. Boniva, Actonel, Fosamax)
__ Asthma
__ Diabetes
__ Thyroid issues
__ Hepatitis A, B, C
__ Hemophilia
__ Epilepsy or seizures
__ Psychiatric treatment
__ Artificial joints
__ Anemia
__ AIDS or HIV+
__ Congenital heart lesions
__ Tuberculosis or lung disease
__ Sinus issues
__ Liver disease
__ Glaucoma
__ Shingles
__ Cancer/chemotherapy/radiation
__ Blood transfusion
__ Fainting
__ Hard of hearing

Additional conditions not listed above: ____
____

Major surgeries (type and year): ____
____
____
____

Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, vitamins, herbal remedies and supplements.

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____
____

Yes	No	
☐	☐	Have you been asked by your medical doctor to pre-medicate before any dental treatment?
☐	☐	Have you taken Fen-Phen, Redux? If yes, have you seen a physician for a cardiac evaluation?
☐	☐	Do you smoke or use chewing tobacco? If yes, how much per day? ______________________________
☐	☐	Do you use controlled substances? If yes, type? ____

Yes	No	
☐	☐	Are you pregnant? If yes, due date: ________________
☐	☐	Are you taking birth control pills?
☐	☐	Are you nursing?

Authorization: I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Signed: ____ Date: _________________________