

DENTAL HISTORY

Patient: Last Name _____ First Name _____ MI _____

How long since your last dental visit? _____ Last cleaning _____ Last X-rays? _____

Former dentist _____ City _____ State _____

Would you make any changes to your teeth? _____

Would you consider lightening your teeth? _____

Do you have any special concerns about your visit? Fear Time Cost Other _____

Anything else you would like us to know? _____

Please mark "Yes" or "No" to indicate if you have, or have ever had, any of the following:

Bleeding Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gums Swollen/ Tender	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking/Popping Jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Cold	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Collection Between Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Hot	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wear a Night Guard	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding/Clenching	<input type="checkbox"/> Yes <input type="checkbox"/> No	Broken Teeth/Fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No		

MEDICAL HISTORY

Physician's Name _____ Phone # _____ How long since last visit? _____

Please mark "Yes" or "No" to indicate if you have, or have ever had, any of the following:

AIDS/HIV	<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
Artificial Heart Valve	<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
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reflux/ GERD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Require Pre-Med	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<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
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<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	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you drink alcohol? Yes No How often? _____

Do you use tobacco? Yes No How much per day? _____ Type of tobacco: Cigarettes Cigars Pipe Smokeless

WOMEN: Are you pregnant? _____ How far along? _____ Nursing? _____

List any surgeries that you have had _____

Notes _____

MEDICATIONS

Please list medications you are taking (prescription & over-the-counter).

Have you ever taken medication for osteoporosis? _____

Pharmacy Name _____

Pharmacy Phone # _____

ALLERGIES

None Aspirin Codeine Latex Penicillin Sulfa

Other _____

