Patient's Name_____

Dental History

Reason for your visit today? _____

_____

Are you currently in pain? ☐Yes ☐No

Do you require antibiotics before dental treatment? ☐Yes ☐No

Your current dental health is: ☐Good ☐Fair ☐Poor

Have you ever had a serious/difficult problem associated with any previous dental work? ☐Yes ☐No

Do you floss daily? ☐Yes ☐No Do you brush daily? ☐Yes ☐No

Type of bristles on your toothbrush ☐Hard ☐Medium ☐Soft

Have you ever had gum treatment? ☐Yes ☐No

Do your gums bleed? ☐Yes ☐No Ever Hurt? ☐Yes ☐No

Have you ever had periodontal disease? ☐Yes ☐No

Have you ever had periodontal surgery? ☐Yes ☐No

How long ago?_____By Whom?_____

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐Yes ☐No

Are your teeth sensitive to heat, cold or anything else?_____

Do you have mobility in your teeth? ☐Yes ☐No

Do you smoke or use tobacco in any other form? ☐Yes ☐No

Have you had any metal rods, pins or implants? ☐Yes ☐No

Do you use an electric toothbrush? ☐Yes ☐No

Do you use a water-pik? ☐Yes ☐No

Do you take any prescription/over-the-counter drugs? ☐Yes ☐No

If yes, please list them here. Also include vitamins/ supplements:

_____

_____

Allergies

Are you allergic to any of the following (check yes or no):

☐Y ☐N Aspirin ☐Y ☐N Codeine ☐Y ☐N Dental Anesthetics ☐Y ☐N Erythromycin ☐Y ☐N Jewelry/Metals

☐Y ☐N Latex ☐Y ☐N Penicillin ☐Y ☐N Sulfa ☐Y ☐N Tetracycline ☐Y ☐N Other

Please list any other drugs/materials you may be allergic to:_____

Medical History

Physician_____ Phone #_____

Date of last visit_____ Have you ever had any serious illnesses or operations? ☐Yes ☐No

If yes, list dates and describe:_____

Are you currently under physician care? ☐Yes ☐No If yes, describe_____

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates_____

WOMEN: Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Have you had any of the following (√ yes or no):

☐Yes☐No AIDS/HIV Positive

☐Yes☐No Anemia

☐Yes☐No Angina Pectoris

☐Yes☐No Arthritis/Rheumatism

☐Yes☐No Artificial heart valves

☐Yes☐No Artificial joints/bones

Year of replacement_____

☐Yes☐No Asthma

☐Yes☐No Back problems

☐Yes☐No Bisphosphonate therapy

☐Yes☐No Blood disease

☐Yes☐No Blood thinners

☐Yes☐No Cancer

☐Yes☐No Chemical dependency

☐Yes☐No Chemotherapy

☐Yes☐No Circulatory problems

☐Yes☐No Cortisone treatments

☐Yes☐No Diabetes

☐Yes☐No Epilepsy

☐Yes☐No Fainting

☐Yes☐No Glaucoma

☐Yes☐No Headaches

☐Yes☐No Heart murmur

☐Yes☐No Heart problems

Describe:_____

☐Yes☐No Hemophilia/Abnormal Bleeding

☐Yes☐No Hepatitis

Check one: ☐A ☐B ☐C

☐Yes☐No Herpes/Fever blisters

☐Yes☐No High blood pressure

☐Yes☐No Kidney disease/malfunction

☐Yes☐No Liver disease

☐Yes☐No Low blood pressure

☐Yes☐No Lupus

☐Yes☐No Material allergies

☐Yes☐No Mitral valve prolapse

☐Yes☐No Nervous problems

☐Yes☐No Pacemaker/Heart Surgery

☐Yes☐No Psychiatric care

☐Yes☐No Radiation treatment

☐Yes☐No Rapid weight gain/loss

☐Yes☐No Respiratory disease

☐Yes☐No Rheumatic/Scarlet fever

☐Yes☐No Shortness of breath

☐Yes☐No Stroke

☐Yes☐No Swelling of feet/ankles

☐Yes☐No Thyroid disease/malfunction

☐Yes☐No Tobacco/Drug habit

☐Yes☐No Tuberculosis

☐Yes☐No Ulcer/Colitis