Name:____ Date: __________________

If you are completing this form for another person, what is your relationship to that person?________________________________

DENTAL HISTORY

Purpose of this dental appointment: ____

Date of last dental visit: ______________________________ ; last dental cleaning: ____________________________

Date of last full mouth series of X-rays: ____

Name of previous dentist: _______________________________________ ; City: ________________________________

Are any of your teeth sensitive to: (please circle) cold hot sweets biting pressure

If so, which areas? ____

	(circle)	
Have you noticed any tenderness or swelling in your gums?	Y	N
Do your gums bleed during or after you brush?	Y	N
Have you been instructed about proper home dental care?	Y	N

How often do you brush? ______________________ floss? _____________________

What other dental cleaning aids or devices do you use? ______________________________

Do you have any unpleasant odor or taste in your mouth?	Y	N
If yes, where? ____		
Have you had teeth removed?	Y	N
Have missing teeth been replaced?	Y	N
If yes, how long ago? ____________________________________		
Are you wearing removable dental appliances?	Y	N
Are you aware that you may be clenching or grinding your teeth?	Y	N
Do you have popping or clicking noises in your ear when you chew or yawn?	Y	N
Do your jaws feel tired, especially in the morning?	Y	N
Do you have pain in front of or behind your ears?	Y	N
If so, which side? right left both		
Do you seem to have frequent headaches, neckaches or shoulder aches?	Y	N
Have you had orthodontic treatment?	Y	N
Have you ever had a very unpleasant dental experience?	Y	N
Describe: ____		
Would you change anything in the appearance or function of your teeth?	Y	N
Describe: ____		

MEDICAL HISTORY

In the following questions, circle, Yes or No, whichever applies:

1) Are you in good health? Y N 2) Date of last physical examination:____________________________

3) Has there been any change in your general health within the past year? Y N

What? ____

4) Are you currently under the care of a physician? Y N

For what condition(s)? ____

Physician's Name: ______________________________________ Phone No. ________________________________

5) Have you had any serious illness or operation within the past 5 years? Y N

What? ____

6) Please list current medications, drugs or pills and dosages: ______________________________

____

____

7) Have you ever taken prescription weight-loss medication (e.g. *Phen-fen*)? Y N

8) Have you ever taken any oral or intravenous drugs for osteoporosis or bone tumors (e.g. *Fosamax*)? Y N

9) Are you allergic or have you reacted adversely to: (Circle if Yes)

local anesthetics *penicillin* *sulfa drugs* *sedatives* *aspirin* *latex* *metals* *other*______________

10) Do you or have you had any of the following diseases or problems? (Circle Yes or No)

Cardiovascular		
heart attack	Y	N
congestive heart failure	Y	N
high blood pressure	Y	N
cardiac pacemaker	Y	N
angina	Y	N
heart murmur	Y	N
damaged or artificial heart valves	Y	N
rheumatic fever	Y	N
stroke	Y	N

Musculoskeletal		
arthritis	Y	N
seizures	Y	N
neurological disorder	Y	N
paralysis	Y	N
fainting spells	Y	N
joint replacement	Y	N

Hematology/ Immunology		
anemia	Y	N
bleeding disorder	Y	N
blood transfusion	Y	N
cancer treatment	Y	N
immunosuppresive disorder	Y	N
kidney disease	Y	N
glaucoma	Y	N

Respiratory		
shortness of breath	Y	N
asthma	Y	N
tuberculosis	Y	N
persistent cough	Y	N

Digestive		
jaundice	Y	N
hepatitis *A B C other*	Y	N
cirrhosis	Y	N
ulcers	Y	N
gastronintestinal disorder	Y	N
chronic diarrhea	Y	N

Endocrine		
diabetes	Y	N
thyroid disorder	Y	N
hormonal disorder	Y	N

Women: Are you?		
currently pregnant	Y	N
nursing	Y	N
taking oral contraceptives	Y	N
hormonal therapy	Y	N

11) Do you have any health condition(s) not listed above that you think we should know about? Y N

If so, explain ______________________________

12) Do you smoke, vape, or use tobacco? Y N If so, how much? ______________________________

13) Are you using any recreational drugs? Y N If so, what? ______________________________

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform my doctor at my next appointment.

Signature: ______________________________ Date: ______________

Reviewed By: ____________________ Date: ______________ BP _____/_____ Pulse: ________bpm Temp: ________

Doctor's Notes: ______________________________

____