# Dental Health History

Reviewed by: DDS1 ☐
DDS2 ☐
DDS4 ☐

## Dental History

Patient Name:_____
Reason for Today's Visit _____ Date of last dental care_____
Former Dentist_____ Date of last dental X-rays_____
Address_____

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

| | | | |
|---|---|---|---|
| ☐ Bad Breath | ☐ Food Collection | ☐ Periodontal Treatment | ☐ Sensitivity when biting |
| ☐ Bleeding Gums | ☐ Grinding Teeth | ☐ Sensitivity to Hot or Cold | ☐ Sensitivity to Sweets |
| ☐ Clicking or Popping Jaw | ☐ Loose Teeth | ☐ Broken Fillings | ☐ Sores or growth in mouth |

How often do you floss? _____ How often do you brush? _____

## Medical History

Physician's Name_____ Date of Last visit_____

Have you ever taken any of the group of drugs collectively referred to as Bisphosphonates? These include Zometa, Fosamax, Actonel, Boniva, Reclast, Aredia, Phenphen, Redux Etc. _____
Have you had any serious illness or operations?_____ If yes, Describe_____
Have you ever had a blood transfusion? _____ If yes, give approximate date_____

(Women) Are you Pregnant? Yes or No Nursing? Yes or No Taking birth control pills? Yes or No

Check if you have or have had any of the following:

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Cortisone Treatment | ☐ Hepatitis | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Artificial Heart Valve | ☐ Diabetes | ☐ HIV/AIDS | ☐ Stroke |
| ☐ Artificial Joints | ☐ Epilepsy | ☐ Jaw Pain | ☐ Swelling of Feet or Ankles |
| ☐ Asthma | ☐ Fainting | ☐ Kidney Disease | ☐ Thyroid Problems |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Liver Disease | ☐ Tobacco Habit |
| ☐ Cancer | ☐ Headaches | ☐ Mitral Valve Prolapse | ☐ Tonsillitis |
| ☐ Chemical Dependency | ☐ Heart Murmur | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Radiation Treatment | ☐ Ulcer |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Respiratory Disease | ☐ Venereal Disease |

## Medications

List Medications you are currently taking:_____
_____
_____
Pharmacy Name:_____
Phone (_____) _____

## Allergies

| | |
|---|---|
| ☐ Aspirin | ☐ Penicillin |
| ☐ Barbiturates (Sleeping Pills) | ☐ Sulfa |
| ☐ Codeine | ☐ Latex |
| ☐ Local Anesthetic | ☐ Other |

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Date_____ Signature_____