Dental History

Name ______________________

Date of last Dental Exam ______________________ Previous Dentist's name ______________________

If you could, what would you change about your smile/teeth? ______________________

	YES	NO
Are you having dental discomfort at this time?	❑	❑
Do you feel nervous about dental treatment?	❑	❑
Have you been treated for periodontal disease?	❑	❑
Do your gums bleed while brushing or flossing?	❑	❑
Are your teeth sensitive to hot or cold liquids or fluids?	❑	❑
Are your teeth sensitive to sweet liquids or foods?	❑	❑
Have you had any head, neck or jaw injuries?	❑	❑
Do you have sores, swelling, or blisters on your gums, cheeks or lips?	❑	❑
Have you had Orthodontic treatment to straighten your teeth?	❑	❑
Do you grind or clench your teeth?	❑	❑
Have you ever experienced clicking or popping jaws, pain in or near the ear, or difficulty in opening your mouth?	❑	❑

Medical History

How would you describe your general health? ❑ Good ❑ Fair ❑ Poor Date of last medical exam ______________________

	YES	NO	
Are you now under the care of a physician?	❑	❑	If so, for what? ______________________
Have you been hospitalized within the last 2 years?	❑	❑	If so, for what? ______________________

List any drugs or medications you are taking at this time: ______________________

	YES	NO	
Are you allergic or sensitive to any drugs?	❑	❑	______________________
Female patients, are you pregnant?	❑	❑	

Please check if you have (or had) any of the following:

- ❑ Mitral valve prolapse
- ❑ Anemia
- ❑ Diabetes
- ❑ High blood pressure
- ❑ Emphysema
- ❑ AIDS virus
- ❑ Artificial heart valve
- ❑ Sinus trouble
- ❑ Blood transfusion
- ❑ Hemophilia
- ❑ Artificial joint, pins, plate
- ❑ Chemotherapy
- ❑ Heart disease
- ❑ Ulcers
- ❑ Smoke or chew tobacco
- ❑ Congenital heart lesion
- ❑ Hay fever
- ❑ Liver disease
- ❑ Drug addiction
- ❑ Nervousness
- ❑ Xray/cobalt treatment
- ❑ Angina
- ❑ Cancer
- ❑ Alcoholism
- ❑ Rheumatic fever
- ❑ Asthma
- ❑ Hepatitis B
- ❑ Heart surgery
- ❑ Epilepsy/seizures
- ❑ Head injury
- ❑ Heart failure
- ❑ Stroke
- ❑ Arthritis
- ❑ Heart murmur
- ❑ Tuberculosis
- ❑ Hepatitis A
- ❑ Heart pacemaker
- ❑ Thyroid disease
- ❑ Fainting/dizzy spells
- ❑ Sexually transmitted diseases

Patient's Family Physician ______________________ Phone ______________________

Address ______________________

(office use only) Verification of Review ______________________ Date ______________________

Medical History (Office Use Only)

Date ______________________ BP ______________________ P ______________________

Notes ______________________

Notes	Medications	Allergies
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
Signature of Patient ______________________	____________	____________
Signature of Dr. or RDH ______________________	____________	____________