Dental History

Please list your present health concerns or problems _____

Current Dentist _____ Date of last dental care _____

Address _____ Date of last dental X-rays _____

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

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

Medical History

When was your last physical exam? _____

Physician's Name _____ Phone _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
Please describe: _____		
2. Have you ever had any serious illnesses or operations?	☐	☐
Please describe: _____		
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you need to premedicate before any Dental treatment?	☐	☐
If yes, list medication & dose _____		

5. Have you had any allergic reactions to the following:

	Yes	No
Penicillin or other Antibiotics	☐	☐
Latex	☐	☐
Local Anesthetics (eg. novocaine)	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (Sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

Please describe: _____

6. Women Only:

	Yes	No
Are you taking birth control pills?	☐	☐
Are you pregnant?	☐	☐
Are you nursing?	☐	☐

Have you had the following:

	Yes	No
Anemia (Low blood count)	☐	☐
Asthma	☐	☐
Back Problems	☐	☐
Bleeding Tendency	☐	☐
Blood Disease	☐	☐
Cancer	☐	☐
Chemical Dependency	☐	☐
Chemotherapy	☐	☐
Circulatory Problems	☐	☐
Congenital Heart Lesions	☐	☐
Cough - persistent or bloody	☐	☐
Diabetics	☐	☐
Epilepsy	☐	☐
Heart Murmur	☐	☐
Heart Disease	☐	☐
Hepatitis-Type	☐	☐
Herpes	☐	☐
High Blood Pressure	☐	☐
HIV/AIDS	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Migraine Headaches	☐	☐
Mitral Valve Prolapse	☐	☐
Pacemaker	☐	☐
Psychiatric Care	☐	☐
Respiratory Disease	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Shortness of Breath	☐	☐
Sinus Trouble	☐	☐
Skin Rash	☐	☐
Stroke	☐	☐
Thyroid Problems	☐	☐
Tuberculosis	☐	☐
Ulcer	☐	☐
Venereal Disease	☐	☐
Any Other Condition	☐	☐

Please describe: _____

Signature

Please note: Payment is due in full at the time of treatment. Thank you.

Signature of Responsible Party _____ **Date** _____