MEDICAL AND DENTAL HISTORY INFORMATION

Name: _____ Date: _____

Dental History:

Last Dental Visit: _____ Reason for today's visit? _____

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

Do your gums bleed when you brush?	Yes	No	Do you have problems with bad breath?	Yes	No
Have you ever had an oral cancer screening?	Yes	No	Do you snore?	Yes	No
Have you or family member been treated for periodontal disease?	Yes	No	Have you ever had a popping or clicking near your ear when you chew?	Yes	No
Have you ever had complications from an extraction?	Yes	No	Are you prone to frequent headaches?	Yes	No
Do you have sores, blisters or swelling on your gums, lips or cheeks?	Yes	No	Have you ever had an allergic reaction to a crown or a metal filling?	Yes	No
Do you grind or clench your teeth?	Yes	No	Are your teeth sensitive to hot, cold or pressure?	Yes	No
Have you ever used an electric toothbrush?	Yes	No	Have you ever had orthodontic treatment?	Yes	No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be: _____

Medical History:

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	High Blood Pressure	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Cholesterol	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy/Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Osteoporosis	Yes	No	Tumors of Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Pain in Jaw Joint	Yes	No	Ulcers	Yes	No
Cold Sores	Yes	No	Heart Murmur	Yes	No	Parathyroid Disease	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Psychiatric Care	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Radiation Treatment	Yes	No			
						Recent Weight Loss	Yes	No			

Are you under a physician's care now? Yes No Physician's Name & Number: _____

Have you been hospitalized or had major operation? Yes No Have you had any serious illness not listed above?_____

Are you Allergic to any of the following? **Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Bananas**

Other: _____

Are you taking or have you ever taken bisphosphonates? (Fosamax, Boniva, Actonel for osteoporosis, chemotherapy, etc) Yes No

Do you use tobacco? Yes No Do you use controlled substances? Yes No

Women Only: ☐ Pregnant/Trying to get Pregnant? ☐ Nursing ☐ Taking Oral Contraceptives?

Please list all medications you are taking: _____

_____

_____

_____

Patient (Parent/Guardian): _____ Date: _____

Doctor: _____ Date: _____