DENTAL HISTORY

Please check any of the following problems Do you smoke or use
chewing tobacco? Y__N__
that apply to you.

-Sensitivity (hot, cold, sweet) __ If I could change my
smile, I would: Where? UR LR UL LL

-Make them whiter __

-Headaches, earaches, neck pain __ -Make them
straighter __

-Jaw joint pain __ -Close spaces
__

-Teeth or fillings breaking __ -Replace dark metal
fillings with

-Grinding or clenching teeth __ tooth colored
restorations __

-Bleeding, swollen or irritated gums __ -Repair chipped
teeth __

-Loose, tipped or shifting teeth __ -Replace missing
teeth __

-Bad breath __ -Replace old
crowns that don't match __

Do you have or have you had any of the following? -Have a smile
makeover __

-Dentures __

-Partial dentures __ What is the most
important thing to you about your

-Braces __ smile and dental
health?______________________

-Periodontal (gum) treatments __
____

Please share the following dates:

Your last cleaning/exam _______ What is the most
important thing to you about your

Your last dental X-rays _______ dental visit today?
____

Name of previous dentist ________________
____

MEDICAL HISTORY

Please check any of the following that apply to you:

__AIDS	__Dizziness	__HIV Positive
__Rheumatism		
__Allergies (Seasonal)	__Drug Addiction	__Jaundice
__Scarlet Fever		
__Anemia	__Emphysema	__Jaw Joint Pain
__Seizures		
__Angina (Chest Pain)	__Excessive Bleeding	__Kidney Disease
__Stomach Problems		
__Arthritis	__Fainting	__Liver Disease
__Stroke		
__Artificial Heart Valve	__Glaucoma	__Low Blood Pressure
__Thyroid Disease		
__Artificial Joints	__Heart Conditions	__Mitral Valve Prolapse
__Tuberculosis		
__Asthma	__Heart Lesions (Congenital)	__Nervousness/Depression
__Ulcers		
__Blood Disease	__Heart Murmur	__Pacemaker
__Venereal Disease		
__Bruise Easily	__Heart Surgery	__Phen Fen (1 month +)
__Other		
__Cancer	__Hepatitis A	__Pregnant Currently
__Chemotherapy	__Hepatitis B	__Radiation Treatment
__Cortisone Medication	__Hepatitis C	__Respiratory Problems
__Diabetes	__High Blood Pressure	__Rheumatic Fever

Do you have any of the following allergies? Are you currently under a physician's care? What for?

__Aspirin __Erythromycin

____

__Codeine __Penicillin

__Sulfa __Local Anesthetic Physician's Name

Phone Number

__Latex __Other _________________

____

Please write any and all medications you are currently taking, or provide list:_________________________________

____

____

____

____

Patient Signature ___________________________________ Date __________ Dentist

Signature_________________
(Parent of Child)