

## Dental History

Previous Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_ Last X-Rays \_\_\_\_\_

Reasons for changing dentists \_\_\_\_\_

Are you nervous about going to the dentist? **Y N** If yes, please tell why. \_\_\_\_\_

Any difficulties during previous treatment? \_\_\_\_\_

How often do you brush? \_\_\_\_\_

How are your flossing habits? \_\_\_\_\_

### (Please check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> I clench my teeth during the day or night                  | <input type="checkbox"/> I have had a jaw injury                        |
| <input type="checkbox"/> I wake up with headaches or jaw soreness                   | <input type="checkbox"/> I avoid chewing in certain areas of my mouth   |
| <input type="checkbox"/> I have pain in or around my ears                           | <input type="checkbox"/> My gums feel tender or swollen                 |
| <input type="checkbox"/> My gums bleed while brushing or flossing                   | <input type="checkbox"/> I have growths or sore spots in my mouth       |
| <input type="checkbox"/> I have problems chewing my food                            | <input type="checkbox"/> I take medication prior to dental appointments |
| <input type="checkbox"/> I would like to change the color or appearance of my teeth |   |

## Medical History

Do you have any of the following?

- |  |  |                                 |
|--|--|---------------------------------|
| <b>Y N</b> Heart disease               | <b>Y N</b> Herpes                            | <b>Y N</b> Venereal disease     |
| <b>Y N</b> Heart murmur                | <b>Y N</b> HIV Positive                      | <b>Y N</b> Arthritis            |
| <b>Y N</b> Abnormal blood pressure     | <b>Y N</b> Asthma                            | <b>Y N</b> Hearing loss         |
| <b>Y N</b> Tuberculosis                | <b>Y N</b> Sinus trouble                     | <b>Y N</b> Fainting spells      |
| <b>Y N</b> Diabetes                    | <b>Y N</b> Liver disease                     | <b>Y N</b> Kidney disease       |
| <b>Y N</b> Epilepsy/seizures           | <b>Y N</b> Tumors or growths                 | <b>Y N</b> Hepatitis type _____ |
| <b>Y N</b> Mitral valve prolapse       | <b>Y N</b> Immune disorder                   | <b>Y N</b> Cancer               |
| <b>Y N</b> Rheumatic fever             | <b>Y N</b> Jaundice                          | <b>Y N</b> Emotional problems   |
| <b>Y N</b> Prolonged bleeding disorder | <b>Y N</b> Excessive urination and/or thirst |                                 |

**Y N** I smoke or use chewing tobacco. How many years? \_\_\_\_\_

**Y N** I have been treated with radiation therapy (other than diagnostic)

**Y N** I am pregnant Due Date \_\_\_\_\_

**Y N** I have had major surgery Year \_\_\_\_\_ Type \_\_\_\_\_

**Y N** I have an adverse reaction to some types of jewelry

### Are you allergic to any of the following?

**Y N** Aspirin

**Y N** Sulfa Drugs

**Y N** Penicillin

**Y N** Local Anesthetic (Novocaine)

**Y N** Other Medications Which ones? \_\_\_\_\_

### Please list all medications you are currently taking

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Condition \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Condition \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Condition \_\_\_\_\_

X \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Patient's or Guardian's Signature