Dental History

Last Dental Visit_____ Recent Dental X-rays? Bitewings_____ Complete series or Panorex_____

What brought you to our office?_____

Do you pre-medicate before dental appointments?_____

How often do you brush?_____ Floss?_____

Are you satisfied with your smile?_____

Please check any conditions or concerns:

Sensitivity to hot or cold	____	Dry Mouth	____	Periodontal/gum treatment	____
Bleeding gums	____	Braces	____	Swollen or painful gums	____
Sores or growths in mouth	____	Frequent Headaches	____	Food collection between teeth	____
Clenching/Grinding teeth	____	Pain around ear	____	Sensitivity when biting	____
Lip or Cheek biting	____	Jaw, head or neck injury	____	Chewing on one side of mouth	____
Chewing difficulty	____	Jaw clicking or pain	____	Burning sensation in mouth	____
Loose teeth	____	Tooth wear	____	Tooth extractions	____
Broken fillings	____	Toothache	____	Other_____	
Halitosis/Bad breath	____	Ice chewing	____	_____	

Medical History

Physician's Name_____Phone Number_____

Any current medical conditions or illness?_____

Tobacco use now or in past?_____ Alcohol use?_____

Allergies:

Penicillin or other antibiotics_____
Local anesthetics (novocaine)_____
Sedatives Barbiturates____ Sulfa drugs____
Aspirin _____ Epinephrine____
Latex _____ Codeine_____
Other_____

Women: Are you (or might you be) pregnant?_____
Nursing?_____
Birth control?_____
Bisphosphonates (Fosomax)?_____

Medications:
Please list all medications, supplements and OTC drugs

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Please check all that apply now or in the past:

Acid Reflux (GERD)	____	Cough-persistent or bloody	____	Radiation Treatment	____
Anxiety	____	Diabetes	____	Respiratory Disease	____
Anemia	____	Depression	____	Rheumatic Fever	____
Arthritis, Rheumatism	____	Glaucoma	____	Scarlet Fever	____
Artificial Heart Valve	____	Head or Neck Injury	____	Seizures	____
Artificial Joints	____	Head or Neck Tumors	____	Sinus Trouble	____
Asthma	____	Heart Murmur	____	Skin Rash	____
Back Problems	____	Hearing Loss (Aids)	____	Stent	____
Bleeding (prolonged)	____	Hepatitis	____	Stroke	____
Blood Disease	____	High Blood Pressure	____	Swelling, Feet or ankles	____
Cancer	____	Kidney Disease	____	Swollen Neck Glands	____
Chemotherapy	____	Liver Disease	____	Thyroid Problems	____
Chronic Fatigue Syndrome	____	Low Blood Pressure	____	Tuberculosis	____
Circulatory Problems	____	Mitral Valve Prolapse	____	Ulcers	____
Congenital Heart Condition	____	Osteoporosis/Osteopenia	____	HPV	____
Cortisone Treatment	____	Pacemaker	____	Other _____	

Signature_____ Date_____