

**DENTAL HEALTH HISTORY**  
(confidential)

**DENTAL HISTORY**

Reason for today's visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

Address \_\_\_\_\_

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

- |                                                        |                                                         |                                                        |
|--------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding Teeth                 | <input type="checkbox"/> Sensitivity to hot            |
| <input type="checkbox"/> Bleeding Gums                 | <input type="checkbox"/> Loose Tooth or Broken Fillings | <input type="checkbox"/> Sensitivity to sweets         |
| <input type="checkbox"/> Clicking or Popping Jaw       | <input type="checkbox"/> Periodontal Treatment          | <input type="checkbox"/> Sensitivity When Biting       |
| <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Sensitivity to Cold            | <input type="checkbox"/> Sores or Growth in Your Mouth |

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? Those include combinations of Ionimin, Adipex, Fastin (names of phentamine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  yes  no

Is patient covered by additional insurance?

Have you had any serious illnesses or operations?  yes  no If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  yes  no If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  yes  no Nursing  yes  no Taking birth control pills?  yes  no

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

- |                                                 |                                               |                                                |                                                         |
|-------------------------------------------------|-----------------------------------------------|------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever                  |
| <input type="checkbox"/> Arthritis, Rheumatism  | <input type="checkbox"/> Cough, Persistant    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath            |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Skin Rash                      |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of the Feet or Ankles |
| <input type="checkbox"/> Back Problems          | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problem                |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit                  |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                    |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tuberculosis                   |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcer                          |
| <input type="checkbox"/> Circulatory Problems   | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease               |

**MEDICATIONS**

List medications you are currently taking: \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone \_\_\_\_\_

**ALLERGIES**

- |                                                       |                                     |
|-------------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Asprin                       | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbituates (sleeping pills) | <input type="checkbox"/> Sulfa      |
| <input type="checkbox"/> Codeine                      | <input type="checkbox"/> Latex      |
| <input type="checkbox"/> Local Anesthetic             | <input type="checkbox"/> Other      |
- : \_\_\_\_\_

**SIGNATURE**

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date \_\_\_\_\_ Signature \_\_\_\_\_