Dental History

Patient Name:_____

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:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food Collection
- ☐ Grinding Teeth
- ☐ Loose Teeth
- ☐ Periodontal Treatment
- ☐ Sensitivity to Hot or Cold
- ☐ Broken Fillings
- ☐ Sensitivity when biting
- ☐ Sensitivity to Sweets
- ☐ Sores or growth in mouth

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

Any Breathing or snoring problems? _____

Medical History

Physician's Name_____ Date of Last visit_____

Have you ever taken any of the group of drugs collectively referred to as **Bisphosphonates**? These include **Zometa, Fosamax, Actonel, Boniva, Reclast, Aredia,** Etc. _____

Have you had any serious illness or operations? _____ If yes, Describe_____

Have you ever had a blood transfusion? _____ If yes, give approximate date_____

Are you taking **Blood Thinners** (Eliquis, Coumadin, Plavix, Xarelto, Aspirin, Ect.) _____

(Women) Are you Pregnant? Yes or No Nursing? Yes or No Taking birth control pills? Yes or No

Check if you have or have had any of the following:

- ☐ Alcohol/Drug Dependency
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints (any)
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cardiac Stent
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cortisone Treatment
- ☐ Circulatory Problems
- ☐ Cold Sores
- ☐ Cough, Persistent
- ☐ Diabetes (Type 1 or 2)
- ☐ Epilepsy
- ☐ Fainting
- ☐ Gastric Reflux
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack (date:_____)
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ History of Infective Endocarditis
- ☐ Hemophilia
- ☐ Hepatitis (Type_____)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Repaired Heart Defect
- ☐ Respiratory Disease
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Disease
- ☐ Smoking
- ☐ Stroke
- ☐ Swelling: Feet or Ankles
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer

Medications

List Medications (Rx and Over the counter) you are currently taking:_____
_____
_____
_____
_____

Pharmacy Name:_____
Phone (_____) _____

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other

Others: _____
_____
_____

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 completion of this form.

Date_____ Signature_____