

Dental History

Reason for Today's Visit	Patient Name:				
Former Dentist					
Address					
Check if you have had problems with any of the following: Bad Breath Food Collection Periodontal Treatment Sensitivity when biting Bleeding Gums Grinding Teeth Sensitivity to Hot or Cold Sensitivity to Sweets Clicking or Popping Jaw Clocking or Popping Jaw How often do you brush? Sores or growth in mouth How often do you floss?					
Bad Breath Food Collection Periodontal Treatment Sensitivity when biting Bleeding Gums Clicking or Popping Jaw Loose Teeth Sensitivity to Hot or Cold Sensitivity to Sweets Clicking or Popping Jaw Loose Teeth Broken Fillings Sensitivity to Sweets Any Breathing or snoring problems? How often do you brush? Any Breathing or snoring problems? Medical History Physician's Name Date of Last visit					
Bleeding Gums Grinding Teeth Sensitivity to Hot or Cold Sensitivity to Sweets Clicking or Popping Jaw Loose Teeth Broken Fillings Sensitivity to Sweets Any Breathing or snoring problems? How often do you brush?	Check if you have had problems	with any of the following:			
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	Bleeding Gums Clicking or Popping Jaw How often do you floss?	Grinding Teeth Loose Teeth	Sensitivity to Hot or Cold S Broken Fillings S How often do you b	Sensitivity to Sweets Sores or growth in mouth	
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		Medi	cal History		
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.)		IMSON			
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.)	Physician's Name		Date of Last visit_		
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 Circulatory Problems Alcohol/Drug Dependency Circulatory Problems Anemia Cold Sores Arthritis, Rheumatism Cough, Persistent Artificial Heart Valve Diabetes (Type 1 or 2) Asthma Fainting Blood Disease Gastric Reflux Cardiac Stent Glaucoma Cancer Headaches Headaches Mitral Valve Prolapse Chemical Dependency Heart Attack (date:)			· · ·		
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 Circulatory Problems Alcohol/Drug Dependency Circulatory Problems Anemia Cold Sores Arthritis, Rheumatism Cough, Persistent Artificial Heart Valve Diabetes (Type 1 or 2) Asthma Fainting Blood Disease Gastric Reflux Cardiac Stent Glaucoma Cancer Headaches Headaches Mitral Valve Prolapse Chemical Dependency Heart Attack (date:)	Have you had any serious illness	or operations?	If yes, Describe		
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 Circulatory Problems Repaired Heart Defect Anemia Cold Sores Hemophilia Repaired Heart Defect Arthritis, Rheumatism Cough, Persistent High Blood Pressure Scarlet Fever Artificial Heart Valve Diabetes (Type 1 or 2) High Cholesterol Skin Disease Asthma Fainting Kidney Disease Smoking Blood Disease Gastric Reflux Liver Disease Stroke Cardiac Stent Glaucoma Lung Disease Swelling: Feet or Ankles Cancer Headaches Mitral Valve Prolapse Tonsillitis Chemical Dependency Heart Attack (date:) Pacemaker Tuberculosis					
(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: Hemophilia Repaired Heart Defect Anemia Cold Sores Hepatitis (Type) Respiratory Disease Arthritis, Rheumatism Cough, Persistent High Blood Pressure Scarlet Fever Artificial Heart Valve Diabetes (Type 1 or 2) High Cholesterol Shortness of Breath Asthma Fainting Kidney Disease Smoking Blood Disease Gastric Reflux Liver Disease Stroke Cardiac Stent Glaucoma Lung Disease Swelling: Feet or Ankles Cancer Headaches Mitral Valve Prolapse Tonsillitis Chemical Dependency Heart Attack (date:) Pacemaker Tuberculosis					
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Chest Pain Heart Problems Radiation Treatment	Chemotherapy Chest Pain	Heart Murmur	Osteoporosis Radiation Treatment	Ulcer	

History of Infective Endocarditis

Cortisone Treatment

Medications	Allergies
List Medications (Rx and Over the counter) you are currently taking:	Aspirin Penicillin Barbiturates (Sleeping Pills) Sulfa Codeine Latex Local Anesthetic 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_____