

## 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:)			· · ·		
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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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Alcohol/Drug DependencyCirculatory ProblemsHemophiliaRepaired Heart DefectAnemiaCold SoresHepatitis (Type)Respiratory DiseaseArthritis, RheumatismCough, PersistentHigh Blood PressureScarlet FeverArtificial Heart ValveDiabetes (Type 1 or 2)High CholesterolShortness of BreathArtificial Joints (any)EpilepsyHIV/AIDSSkin DiseaseAsthmaFaintingKidney DiseaseSmokingBlood DiseaseGastric RefluxLiver DiseaseStrokeCardiac StentGlaucomaLung DiseaseSwelling: Feet or AnklesCancerHeadachesMitral Valve ProlapseTonsillitisChemical DependencyHeart Attack (date:)PacemakerTuberculosis	(Women) Are you Pregnant? Yes or No Nursing? Yes or No		No Taking birth control pills?	Taking birth control pills? Yes or No	
AnemiaCold SoresHepatitis (Type)Respiratory DiseaseArthritis, RheumatismCough, PersistentHigh Blood PressureScarlet FeverArtificial Heart ValveDiabetes (Type 1 or 2)High CholesterolShortness of BreathArtificial Joints (any)EpilepsyHIV/AIDSSkin DiseaseAsthmaFaintingKidney DiseaseSmokingBlood DiseaseGastric RefluxLiver DiseaseStrokeCardiac StentGlaucomaLung DiseaseSwelling: Feet or AnklesCancerHeadachesMitral Valve ProlapseTonsillitisChemical DependencyHeart Attack (date:)PacemakerTuberculosis	Check if you have or have had ar	ny of the following:			
Artificial Heart ValveDiabetes (Type 1 or 2)High CholesterolShortness of BreathArtificial Joints (any)EpilepsyHIV/AIDSSkin DiseaseAsthmaFaintingKidney DiseaseSmokingBlood DiseaseGastric RefluxLiver DiseaseStrokeCardiac StentGlaucomaLung DiseaseSwelling: Feet or AnklesCancerHeadachesMitral Valve ProlapseTonsillitisChemical DependencyHeart Attack (date:)PacemakerTuberculosis	Alcohol/Drug Dependency	Circulatory Problems			
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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\_\_\_\_\_