Dental History

PatientName:______________________________Email:______________________________
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
- [ ] Other (Please List)

Medications	Allergies
List Medications (Rx and Over the counter) you are currently taking:____ ____ ____ ____ ____ Pharmacy Name:___________________________________ Phone (______) ___________________________________	☐ 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____