



# Dental/Medical Health History

*Confidential*

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last First Middle Initial

## Dental History

Reason For Today's Visit \_\_\_\_\_

Preferred Dentist/Office \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_

### Check if you have had the following:

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Periodontal treatment
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Sensitivity to cold
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Sensitivity to hot
<input type="checkbox"/> Food collection between teeth	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity when biting
<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sores or growths in your mouth

How often do you brush? \_\_\_\_\_

How often do you floss? \_\_\_\_\_

## Medical History

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

List any serious operations or illnesses:

_____	Date _____

Have you had a blood transfusion? YES NO  
If yes, approx dates \_\_\_\_\_

**Check if you have had the following:**

<input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Artificial Heart Valves <input type="checkbox"/> Artificial Joints <input type="checkbox"/> Asthma <input type="checkbox"/> Back Pain <input type="checkbox"/> Blood Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> Cortisone Treatments <input type="checkbox"/> Cough, Persistent <input type="checkbox"/> Cough up Blood <input type="checkbox"/> Diabetes 1 2 <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fainting <input type="checkbox"/> Glaucoma <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Problems <input type="checkbox"/> Hemophilia	<input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Jaw Pain <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Pacemaker <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Skin Rash <input type="checkbox"/> Stroke <input type="checkbox"/> Swelling of Feet or Ankles <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tobacco Habit <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcer <input type="checkbox"/> Venereal Disease
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**Medications**

<b>List Medications you are currently taking:</b> _____ _____ _____  Pharmacy Name _____ Phone: _____	<b>Allergies:</b> <input type="checkbox"/> Aspirin <input type="checkbox"/> Barbiturates (Sleeping Pills) <input type="checkbox"/> Codeine <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Latex <input type="checkbox"/> Other _____
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**Signature**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the office of any changes in health.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient