DENTAL HISTORY FORM

Patient Name:____ Date:_______________________

What is the main reason for your visit today?____

What is the date of your last dental appointment? ____

Please check any symptoms that you have had or currently have today:

____Abnormal Bleeding after Extraction
____Bad Breath/Bad Taste
____Bleeding Gums
____Broken Fillings
____Burning Mouth
____Dry Mouth
____Gum Disease
____Grinding/Clenching
____ Jaw Pain/Popping/Clicking
____Loose Tooth/Teeth
____ Problems Biting/Chewing
____Sensitive(hot/cold/sweets)
____ Sores/Growths in Mouth
____ Swelling
____ Toothache

Have you ever been advised to take antibiotics before dental appointments? ☐ Yes ☐ No

MEDICAL HISTORY:
Are you currently under the care of a medical doctor? ☐ Yes ☐ No
Physician's name and phone number:____

Please list all prior operations and hospitalizations with dates:____

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WOMEN: Are you currently pregnant? ☐ Yes ☐ No If yes, due date:_______________________

Are you nursing? ☐ Yes ☐ No Do you take birth control pills? ☐ Yes ☐ No

Please check any of the following you have or have had:

____Abnormal Bleeding
____Alcohol Abuse
____Allergies
____Anemia
____Anxiety/Panic Attacks
____Arthritis
____Artificial Heart Valve
____Artificial Joints (knee/hip)
____Asthma
____Back Problems
____Blood Disease
____Blood Thinner Meds (Aspirin/Plavix/Coumadin,etc.)
____Cancer:_______________________
____Chemotherapy
____Cortisone Treatments
____Cough (persistent)
____Emphysema
____Depression
____Diabetes
____Drug Addiction
____Epilepsy/Seizures
____Fainting/Dizziness
____Glaucoma
____Headaches
____Heart Attack
____Heart Murmur
____Heart Pacemaker
____Heart Problems
____Heart Surgery
____Hemophilia
____Hepatitis A B C
____High Blood Pressure
____HIV/AIDS
____Kidney Disease
____Liver Disease
____Mitral Valve Prolapse
____Psychiatric Treatment
____Radiation Treatment
____Recreational Drugs
____Shortness of Breath
____Sinus Trouble
____Skin Rash
____Stroke
____Swelling of Feet/Ankles
____Thyroid Problems
____Tobacco:_____________
____Tonsillitis
____Tuberculosis (TB)
____Ulcer
____Venereal Disease/STD
____Other:_______________

Do you currently take or have you taken any medicines for your bones (Boniva,Fosamax,etc)? ☐ Yes ☐ No

Please list any prescription/non-prescription medicines, vitamins, herbs, etc. you may be taking:

____

____

Please list any medications to which you have had an allergic reaction:

____

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I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answer I have given are accurate. I also understand it is very important to report any changes or updates in my medical status.

Patient Name (Printed):___________________________ Patient Signature:_________________________________ Date:______________________

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