Dental History

Why have you come to the dentist today?_____

_____

Are you currently in pain? Yes ☐ No ☐

Do you require antibiotics before dental treatment? Yes ☐ No ☐

Have you experienced problems associated with any previous dental work? Yes ☐ No ☐

Do you now or have you ever experienced Pain/discomfort in your jaw joint (TMJ/TMD)? Yes ☐ No ☐

Do you or have you been told you snore? Yes ☐ No ☐

Do you feel tired during the day? Yes ☐ No ☐

Do you use anything in addition to your brush and floss? Yes ☐ No ☐

If yes, what? _____

Would you like whiter teeth? Yes ☐ No ☐

Previous Dentist? _____Last Visit _____

Address: _____ Phone: _____

Why did you leave your previous dentist? _____

_____

Do you still have wisdom teeth? Yes ☐ No ☐

Are you happy with your smile? Yes ☐ No ☐

If not, what would you change? _____

_____

Do your gums ever bleed? Yes ☐ No ☐

Have you ever had periodontal disease? Yes ☐ No ☐

Do you have mobility in your teeth? Yes ☐ No ☐

Are your teeth sensitive to heat, cold or anything else? Yes ☐ No ☐

Medical History

Do you have a physician? Yes ☐ No ☐

Physician's name: _____

Address: _____

Phone #: _____ Last Visit Date: _____

Your current physical health is: Good ☐ Fair ☐ Poor ☐

Are you currently under the care of a Physician? Yes ☐ No ☐

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Sedatives
Y N	Barbiturates	Y N	Jewelry/Metals	Y N	Sulfa Drugs
Y N	Codeine	Y N	Latex	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Penicillin	Y N	Other

Please list any additional drugs/materials that cause allergic Reactions: _____

Women Only:

Are you taking birth control pills? Y N

Are you pregnant? Unsure ☐ Yes ☐ No ☐ Week #: _____

Are you nursing? Yes ☐ No ☐

ARE YOU TAKING THE FOLLOWING?

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes Drug	Y N Thyroid Medicine
Y N Antibiotics	Y N Blood Pressure Medication	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drug	Have you ever taken Phen-Fen? Also
Y N Aspirin	Y N Digitals/Heart Medication	Y N Steroids/Cortisone	Known as Redux or Pondimin. Y N

Are you taking any prescription, over the counter drugs, herbal remedies, or minerals not listed above? Yes ☐ No ☐

If yes please list each one: _____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Ulcers	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Mitral Valve Prolapse	Y N Stroke
Y N Asthma	Y N Emphysema	Y N Hepatitis	Y N Pacemaker	Y N Thyroid Problems
Y N Blood Transfusion	Y N Epilepsy	Y N Herpes	Y N Persistent Cough	Y N Tonsillitis
Y N Chicken Pox	Y N Fainting Spells	Y N High Blood Pressure	Y N Psychiatric Problems	Y N Tuberculosis (TB)
Y N Artificial Valves	Y N Fever Blisters	Y N HIV/Aids	Y N Radiation Treatment	
Y N Cancer	Y N Glaucoma	Y N Hospitalized	Y N Scarlet Fever	
Y N Chemotherapy	Y N Hay Fever	Y N Kidney Problems	Y N Seizures	

I affirm that the information I have given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status. _____ _____

Print Name Signature Date