DENTAL/HEALTH HISTORY

Patient Name: ______________________________ Today's Date: ______________

Former dentist: ______________________________ Date of last dental visit: ______________________

Reason for visit: ______________________________

DENTAL HISTORY FOR ALL DENTAL PATIENTS:

Have you ever had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No

Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal (gum) treatment	☐ Yes	☐ No
Sensitivity to cold/hot/sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in mouth	☐ Yes	☐ No

How often do you floss? Once a day Twice a day Several times a day Never Other

How often do you brush? Once a day Twice a day Several times a day Never Other

HEALTH HISTORY FOR ALL DENTAL PATIENTS:

Physicians Name: ______________________________ Date of last visit: ______________________________

Have you ever had any of the following:

AIDS/HIV	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back problems	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory problems	☐ Yes	☐ No
Congenital heart lesions	☐ Yes	☐ No
Cortisone treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes (type)	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Do you wear contact lenses?	☐ Yes	☐ No
Epilepsy/seizures	☐ Yes	☐ No
Fainting/dizziness	☐ Yes	☐ No
Frequent colds or ear infections	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart conditions/murmur	☐ Yes	☐ No
Hepatitis (type)	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Immunological problems	☐ Yes	☐ No

Kidney disease	☐ Yes	☐ No
Learning disorders/behavior issues	☐ Yes	☐ No
Liver disease/hepatitis/jaundice	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
Measles/mumps/chicken pox	☐ Yes	☐ No
Nervous problem	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Physical abuse	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Psychiatric care	☐ Yes	☐ No
Radiation treatment	☐ Yes	☐ No
Respiratory disease	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Sinus trouble	☐ Yes	☐ No
Skin rash	☐ Yes	☐ No
Special diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen feet or ankles	☐ Yes	☐ No
Stomach problems/frequent vomiting	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
Tonsillitis/frequent strep throat	☐ Yes	☐ No
Transfusions	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Other ______________________________		

Medications

Please list any medications you are currently taking and the reason you are taking it:

Medication	Reason

Have you used a bisphosphonate medication? (Fosamax, Actonel, Atelvia, Didronel, Boniva, ETC.) ☐ Yes ☐ No

Allergies

Aspirin	☐ Yes	☐ No
Sleeping pills	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Iodine	☐ Yes	☐ No
Latex	☐ Yes	☐ No

Local Anesthetic	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Sulfa	☐ Yes	☐ No
Other:_______________________	☐ Yes	☐ No

HEALTH INFORMATION FOR FEMALE DENTAL PATIENTS ONLY:

Are you pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking birth control pills?	☐ Yes	☐ No

If yes, due date: ___________________

HEALTH INFORMATION FOR DENTAL PATIENTS AGED 14 YEARS OR YOUNGER:

Is the child's first visit to the dentist?	☐ Yes	☐ No
Does your child brush his/her own teeth?	☐ Yes	☐ No
Does your child use dental floss?	☐ Yes	☐ No
Do you help your child brush their teeth?	☐ Yes	☐ Date: ___________________________
Do your child's gums bleed when brushing?	☐ Yes	☐ Date: ___________________________
Has your child had trauma to teeth, mouth, or face?	☐ Yes	☐ Date: ___________________________
Do you have fluoridated water?	☐ Yes	☐ No

Was your child premature?	☐ Yes	☐ No
Was your child born with any birth defects?	☐ Yes	☐ No
Was your child breast fed?	☐ Yes	☐ No
Was your child bottle fed?	☐ Yes	☐ No
Does your child attend special classes or schools?	☐ Yes	☐ No

Has your child ever been hospitalized?	☐ Yes	☐ No
Has your child ever been in the emergency room?	☐ Yes	☐ No
Has your child ever had general anesthesia?	☐ Yes	☐ No

If yes to any of the above, please explain:

____

Signature of Patient

____

Date

____

Printed Name of Patient

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