DENTAL HISTORY

What is the reason for your visit today? _____
Are you having pain? □ Yes □ No Do you have mobility in your teeth? □ Yes □ No
Have you ever had periodontal disease? □ Yes □ No Do your gums ever bleed? □ Yes □ No
Do you need to be pre-medicated before any dental work? □ Yes □ No
Have you experienced problems associated with any previous dental work? □ Yes □ No
Do you still have your wisdom teeth? □ Yes □No
Are your teeth sensitive to hot, cold, or anything else? _____
Do you now or have you ever experienced any pain / discomfort in your jaw joint? □ Yes □ No
Your current dental health is, □ Good □ Fair □ Poor
Do you Brush Daily? □ Yes □ No Do you Floss Daily? □ Yes □ No
What type of toothbrush do you use? □Hard □Medium □Soft
How often do you replace your toothbrush? _____
Do you use anything in addition to your brush and floss? □ Yes □ No
If so what? _____
Previous / Present Dentist: _____Phone#_____

MEDICAL HISTORY

Do you have a personal physician? □ Yes □ No Date of Last Visit:_____-_____
Physician's Name: _____Phone#_____
Address:_____
Street City State Zip Phone

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	Y / N	Sulfa Allergy
Y / N	Codeine	Y / N	Latex	Y / N	Tetracycline
Y / N	Dental Anesthetics	Y / N	Penicillin	Y / N	Other

Please list anything in addition that may cause allergic reaction:_____

Are you currently taking any medications? If yes, list all:_____

Do you or have you experienced any of the following?

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

For Women: Are you taking birth control pills? □ Yes □ No
Are you pregnant? □ Unsure □ Yes □ No Week #:_____ Are you nursing? □ Yes □ No