DENTAL HEALTH HISTORY

Confidential

Today's Date: ----------

Patient Name: ---------- Birth Date: ----------
Last First Initial

Dental History

Reason for Today's Visit: ---------- Date of last dental care: ----------

Former Dentist: ---------- Date of last dental X-Rays: ----------

Address: ----------

Please check, if you have had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to Hot
☐ Bleeding Gums	☐ Loose Teeth or broken fillings	☐ Sensitivity to Sweets
☐ Clicking or popping Jaw	☐ Periodontal Treatment	☐ Sensitivity when biting
☐ Food Collection between Teeth	☐ Sensitivity to Cold	☐ Sores or growths in your month

How often do you floss? ---------- How often do you brush? ----------

Medical History

Physician's Name: ---------- Date of Last Visit: ----------

Have you had any serious illnesses or operations? ---------- If yes, describe ----------

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, gives approximately dates ----------

Have you ever taken any of the group of drugs collectively referred to as "fen-phen? These include combinations of lonimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine) ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please check, if you have had or have problems with any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jew Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapsed	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Venereal

Medications

List medications you are currently taking: ----------

Pharmacy Name: ----------

Phone: ----------

Allergies

☐ Aspirin	☐ Barbiturates (Sleeping pills)	☐ Codeine	☐ Local Anesthetic
☐ Penicillin	☐ Sulfa	☐ Latex ----------	☐ Other ----------

Signature

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or mine minor child, ever have a change in health.

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Signature of Parent, Parent, Guardian or Personal Representative Date

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Please print name of Parent, Parent, Guardian or Personal Representative Relationship to Patient