DENTAL HISTORY *(confidential)* *(Rev.9.15)*

*Name*_____ **DENTAL INFORMATION** *Date of Birth* _____

Do you have_____: (please circle)

Bad Breath
Bleeding Gums
Clicking/Popping Jaw
Dental Implants
Dentures/ Partial Dentures
Food Collects Between Teeth
Grinding Teeth
Loose Teeth
Mouth Sores or Growths
Sensitivity to Cold
Sensitivity to Heat
Sensitivity to Sweets
Sensitivity when Biting
Date of last dental visit _____

Have you ever had any serious trouble associated with any previous dental treatment? Yes No *If yes, explain _____

Are you happy with your smile?_____ How often do you brush? _____ How often do you floss? _____

MEDICAL INFORMATION *(confidential)*

Physician's Name _____ Physician Phone #_____

Have you had any **SERIOUS OPERATIONS** in the past 5 years? Yes No **If yes, please list with date.*

Have you had **ORTHOPEDIC JOINT REPLACEMENT**? (hip, knee, elbow, finger, other) Yes No Dates _____

Please CIRCLE if you have you had **HEART VALVE REPLACEMENT, PACEMAKER or MITRAL VALVE PROLAPSE**?

Have you ever been **TREATED FOR ANY OF THE FOLLOWING**: *(please circle)* **MERSA, C-DIFF, STAPH**

(Women only- the next 3 questions. Please answer YES or NO.)

1)Are you PREGNANT?_____ 2)Do you take BIRTH CONTROL pills?____ 3)Do you take **OSTEOPOROSIS MEDS?**____

Please *CIRCLE YES or NO* to EACH of the following MEDICAL CONDITIONS as they relate to YOU

Yes No AIDS/HIV	Yes No Circulatory Problems	Yes No Jaw Pain
Yes No Anemia	Yes No Cortisone Treatments	Yes No Kidney Disease/Problems
Yes No Anxiety/Depression	Yes No Persistent Cough	Yes No Liver Disease/Problems
Yes No Arthritis/Rheumatism	Yes No Cough up Blood	Yes No Radiation Treatment
Yes No Asthma	Yes No Diabetes	Yes No Rheumatic Fever
Yes No Back Problems	Yes No Epilepsy /Seizures /Fainting	Yes No Stroke
Yes No Blood Disease/Clotting issues	Yes No Heartburn / Acid Reflux	Yes No Thyroid Problems
Yes No Cancer (date)_____	Yes No Heart Disease	Yes No Tobacco Habit
Yes No Chemical Dependency	Yes No Hepatitis____ (date)_____	Yes No Tuberculosis
Yes No Chemotherapy	Yes No High Blood Pressure	Yes No Venereal Disease

Yes No Blood Transfusion -- Date _____

Do you have any **DISEASE, CONDITION or PROBLEM NOT LISTED?** _____

ALLERGIES *(please circle)*

LATEX Penicillin/Amoxicillin Erythromycin Aspirin Local Anesthetics Sulfa Codeine
Iodine Barbiturates Sedatives Sleeping Pills Other_____

Please list **MEDICATIONS you are currently taking.** _____

The above information is accurate, to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any omissions or errors that I may have made in the completion of this form.

Date _____ *Signature* _____ *Reviewed by/date*_____

(DO NOT WRITE BELOW – Office Use Only) ***MEDICAL HISTORY UPDATE***

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____