## Dental History

Name _____
(Last) (First) (M.I.)

Former Dentist_____ City & State_____
Date of last exam_____ Date of last dental X-rays_____
Reason for leaving that office_____
Have you had any complications with previous dental treatment or service? _____
If yes, please explain _____
How often do you brush your teeth?_____How often per week do you floss?_____
Have you had orthodontic work?_____

Please check any of the following conditions that apply to you:

- ❑ Bleeding Gums
- ❑ Loose teeth
- ❑ Sores in Mouth
- ❑ Grinding Teeth
- ❑ Broken Fillings
- ❑ Bad Breath
- ❑ Sensitivity to Hot or Cold
- ❑ Sensitivity to Sweet or Sour
- ❑ Food Impaction

Comments:

If anything were possible, what would you change about your smile?

## Medical History

Physician's Name_____ Location of Office_____

Please list all medications you are currently taking. Please list all allergies.

| MEDICATIONS | ALLERGIES |
|---|---|
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Are you currently under the care of a physician? ❑Yes ❑No
If Yes, Please explain_____

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

Do you currently have or have you ever had any of the following?

- ❑AIDS
- ❑Anemia
- ❑Angina
- ❑Arthritis, Rheumatism
- ❑Artificial Heart Valves
- ❑Artificial Joints
- ❑Asthma
- ❑Cancer
- ❑Chemical Dependency
- ❑Chemotherapy
- ❑Circulatory Problems
- ❑Diabetes
- ❑Epilepsy
- ❑Excessive Bleeding
- ❑Fainting
- ❑Glaucoma
- ❑Headaches
- ❑Heart Murmur
- ❑Heart Problems
  Describe_____
- ❑Hemophilia
- ❑Hepatitis
- ❑High Blood Pressure
- ❑HIV Positive
- ❑Implants
- ❑Kidney Disease
- ❑Latex Sensitivity
- ❑Liver Disease
- ❑Low Blood Pressure
- ❑Mitral Valve Prolapse
- ❑Nervous Problems
- ❑Pacemaker
- ❑Psychiatric Care
- ❑Radiation Treatment
- ❑Respiratory Disease
- ❑ Rheumatic Fever
- ❑Scarlet Fever
- ❑Stomach Trouble
- ❑Stroke
- ❑Swelling of Feet/Ankles
- ❑Thyroid Problems
- ❑Tobacco Habit
- ❑Ulcers
- ❑Venereal Disease

Comments:

***I certify that the above information is complete and accurate.***

Patient or Guardian's Signature_____ Date_____

Doctor's Signature_____Date_____

## MEDICAL HISTORY UPDATE

| DATE | COMMENTS | INITIAL | DATE | COMMENTS | INITIAL |
|---|---|---|---|---|---|
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