DENTAL HISTORY

Patient Name:

Reason for today's visit ____________________ Date of last dental care ____________________

Former Dentist ____________________ Date of last dental x-rays ____________________

Contact Information ____________________

Check if you have or 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	Sensitvity to cold	Sores or growths in the mouth

How often do you floss? ____________________ How often do you brush? ____________________

MEDICAL HISTORY

Physician's Name ____________________ Date of last visit ____________________

Contact Information ____________________

Have you ever had any serious illnesses or operations? No Yes: ____________________

Have you ever had a blood transfusion? No Yes: ____________________

(Female) Are you pregnant? No Yes – Due Date: ____________ Taking Birth Control Pills? No Yes

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

Check if you have or have had problems with any of the following:

Anemia	Congenital Heart lesions	Hepatitis	Scarlet Fever
□ Arthritis, Rheumatism	□ Cortisone Treatments	Hernia Repair	Shortness of Breath
□ Artificial Heart Valves	Cough, Persistent	High Blood Pressure	Skin Rash
□ Artificial Joints, Pins, Etc.	Cough up Blood	HIV/AIDS	Stroke
Asthma	Diabetes	Jaw Pain	Swelling of Feet or Ankles
Back problems	Epilepsy	Kidney Disease	Thyroid Problems
Bleeding abnormally	□ Fainting	Liver Disease	Tobacco Habit
Blood disease	Glaucoma	Mitral Valve Prolapse	□ Tonsillitis
Cancer	Headaches	Pacemaker	Tuberculosis
Chemical Dependency	Heart Murmur	Radiation Treatment	Ulcer
Chemotherapy	Heart Problems	Respiratory Disease	Venereal Disease
Circulatory Problems	Hemophilla	Rheumatic fever	

List medications you are currently taking: ____________________

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Allergies:

ASPIRIN	Local Anesthetic	Iodine	Other ____________
Barbiturates (Sleeping Pills)	PENICILLIN	LATEX	____________
CODEINE	SULFA	None	

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 my minor child ever have a change in health.

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PRINT NAME of Parent, Guardian or Personal Representative

____________________ ____________________

Signature of Parent, Guardian or Personal Representative Date