

Patient Name:

Birth Date:

Date Created:

**Dental History**

What is the reason for today's visit?

Comment

Former Dentist (City/State, Phone#)

Comment

Date of last dental visit

Date of last dental X-rays

How often do you brush?

How often do you floss?

Please indicate yes or no if you have had any of the following:

Bad Breath ☐ Yes ☐ No  
 Bleeding gums ☐ Yes ☐ No  
 Blisters on lips or mouth ☐ Yes ☐ No  
 Burning sensation on tongue ☐ Yes ☐ No  
 Chew on one side of mouth ☐ Yes ☐ No  
 Cigarette, pipe, or cigar smoking ☐ Yes ☐ No  
 Clicking or popping jaw ☐ Yes ☐ No  
 Dry mouth ☐ Yes ☐ No  
 Fingernail biting ☐ Yes ☐ No  
 Food collection between teeth ☐ Yes ☐ No  
 Grinding teeth ☐ Yes ☐ No  
 Gums swollen or tender ☐ Yes ☐ No  
 Snoring ☐ Yes ☐ No

Jaw pain or tiredness ☐ Yes ☐ No  
 Lip or cheek biting ☐ Yes ☐ No  
 Loose teeth or broken fillings ☐ Yes ☐ No  
 Mouth Breathing ☐ Yes ☐ No  
 Mouth pain, brushing ☐ Yes ☐ No  
 Orthodontic treatment ☐ Yes ☐ No  
 Pain around ear ☐ Yes ☐ No  
 Periodontal treatment ☐ Yes ☐ No  
 Sensitivity to cold or heat ☐ Yes ☐ No  
 Sensitivity to sweets ☐ Yes ☐ No  
 Sensitivity to biting ☐ Yes ☐ No  
 Sores or growths in your mouth ☐ Yes ☐ No  
 Use CPAP ☐ Yes ☐ No

**Medical History**

Physician's Name

Comment

Date of last visit

Comment

Do you take, or have you taken, Phen-Fen, Redux, Ionimin, Adipex, Fastin, or Pondimin?

☐ Yes ☐ No

Do you wear contact lenses?

☐ Yes ☐ No

Women: Are you...

☐ Pregnant/Trying to get pregnant?☐ Nursing?☐ Taking oral contraceptives?

Please indicate yes or no if you have had any of the following:

AIDS / HIV ☐ Yes ☐ No  
 Arthritis ☐ Yes ☐ No  
 Artificial Heart Valves ☐ Yes ☐ No  
 Artificial Joints ☐ Yes ☐ No  
 Asthma ☐ Yes ☐ No  
 Bleeding abnormally w/ Extractions or su ☐ Yes ☐ No  
 Cancer ☐ Yes ☐ No  
 Chemical Dependency ☐ Yes ☐ No  
 Circulatory Problems ☐ Yes ☐ No  
 Cortisone Treatments ☐ Yes ☐ No  
 Cough, persistent ☐ Yes ☐ No  
 Diabetes ☐ Yes ☐ No  
 Emphysema / COPD ☐ Yes ☐ No

Epilepsy ☐ Yes ☐ No  
 Fainting / Dizziness ☐ Yes ☐ No  
 Headaches ☐ Yes ☐ No  
 Heart Murmur ☐ Yes ☐ No  
 Heart Problems ☐ Yes ☐ No  
 Hepatitis ☐ Yes ☐ No  
 Herpes ☐ Yes ☐ No  
 High Blood Pressure ☐ Yes ☐ No  
 Jaw Pain ☐ Yes ☐ No  
 Kidney Disease ☐ Yes ☐ No  
 Liver Disease ☐ Yes ☐ No  
 Low Blood Pressure ☐ Yes ☐ No  
 Mitral Valve Prolapse ☐ Yes ☐ No

Nervous Problems ☐ Yes ☐ No  
 Pacemaker ☐ Yes ☐ No  
 Radiation Treatment ☐ Yes ☐ No  
 Rheumatic Fever ☐ Yes ☐ No  
 Shortness of Breath ☐ Yes ☐ No  
 Sinus Trouble ☐ Yes ☐ No  
 Skin Rash ☐ Yes ☐ No  
 Stroke ☐ Yes ☐ No  
 Swollen Feet / Ankles ☐ Yes ☐ No  
 Swollen Neck Glands ☐ Yes ☐ No  
 Thyroid Problems ☐ Yes ☐ No  
 Tumor / Growth on head or neck ☐ Yes ☐ No  
 Ulcer ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin☐ Latex☐ Penicillin☐ Codeine☐ Local Anesthetic☐ Sulfa☐ Iodine

Other?

☐ Yes ☐ No

If yes

List Any medications you are currently taking:

Emergency Contact Name:

Emergency Contact Relationship to Patient:

Emergency Contact Phone Numbers (cell / home):