

New Patient Dental/ Medical Health History Form

Dental History

Date of last dental care visit: _____ Former dentist's name: _____ Phone: _____

Check if you have any problem with the following:

- | | |
|--|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Loose teeth or broken fillings |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Clicking or Popping jaw | <input type="checkbox"/> Sensitivity to any of the following: <input type="checkbox"/> cold <input type="checkbox"/> hot <input type="checkbox"/> sweets |
| <input type="checkbox"/> Sensitivity when chewing/biting | <input type="checkbox"/> Grinding/Clenching teeth |

How often do you brush? _____ How often do you floss? _____

Medical History

Primary Care Physician: _____ Date of last visit: _____

Women: are you pregnant? Yes No Are you nursing? Yes No

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis, rheumatism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Artificial joints, pins etc. | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> HIV AIDS | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Thyroid imbalance |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> kidney disease | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Congenital heart failure | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Ulcer |

Are you allergic to any of the following: Penicillin Aspirin Erythromycin Tetracycline

Latex Dental Anesthetics Codeine Sulfa other _____

List all medications you are currently prescribed: _____

Preferred pharmacy: _____

Acknowledgement

I certify that the above information is true and complete to the best of my knowledge

Patient/Guardian Signature: _____ Date: _____