# DENTAL HISTORY

Name: _____Date of Birth:_____

Why have you come to the dentist today?_____

Approximate date of last dental exam:_____

Are you currently in pain? ____Yes ____No If yes, please describe _____

Have you experienced problems associated with any previous dental care? ____Yes ____ No

Do you or have you experienced pain/discomfort in your jaw joint (TMJ, TMD)? ____Yes ___No

Do you floss daily? ____Yes ____No Do you brush daily? ____Yes ____No

Would you like whiter teeth? ____Yes ____No Would you like fresher breath? ____Yes ____No

Are your teeth sensitive? ____Yes ____No If yes: ____hot ____ cold ____Other:_____

Are you happy with the way your smile looks? ____Yes ____No

# MEDICAL HISTORY

Name: _____ Birth Date:_____

Name of physician: _____ Date of last exam:_____

Are you currently under the care of a physician? _____Yes _____No

If yes, please explain: _____

List all current medications that you are taking, include over the counter and herbal supplements.

_____ _____

_____ _____

_____ _____

Please list all allergies to medication: _____

**For Women Only:**

Are you pregnant? ___Yes ___No Are you Nursing? ___Yes ___No
Are you using birth control? ___Yes ___No

Are you aware that antibiotics may reduce the effectiveness of birth control pills? ___Yes ___No

(OVER)

___Yes ___No **Acid Reflux**
___Yes ___No **Alcohol Use**
___Daily ___Social
___Yes ___No **Allergies**
___ Latex Allergy
___Metals, Jewelry
___ Seasonal Allergies
__Yes ___No **Artificial Joints**
___ Hip
___Knee
___Other_____
___Yes ___No **Arthritis**
Type: _____
___Yes ___No **Blood Disorders**
___Anemia
___Bruise Easily
___Excessive Bleeding
___Hemophilia
___Sickle Cell
___Yes ___No **Blood Pressure**
___High
___Low
___Yes ___No **Cancer**
Type: _____
___Chemotherapy
___Radiation
___Yes ___No **Diabetes**
___Yes ___No **Drug Addiction**
___Yes ___No **Epilepsy**
___Fainting Spells
___Seizures
___Yes ___No **Gall Bladder**
___Yes ___No **Glaucoma**
___Yes ___No **Heart Problems**
___ Angina
___ Attack
___ Mitral Valve
___ Rheumatic Fever
___Pacemaker
___ Stents
___ Surgery
___ Other_____

___Yes ___No **Hepatitis**
Type _____
___Yes ___No **Herpes/Cold Sores**
___Yes ___No **HIV/AIDS/ARC**
___Yes ___No **Home Oxygen Use**
___Yes ___No **Implants**
Type_____
___Yes ___No **Kidney Disorder**
___Yes ___No **Liver Disease**
___ Jaundice
___Yes ___No **Lung Disease**
___Asthma
___Emphysema
___Tuberculosis
___Other_____
___Yes ___No **MRSA**
___Yes ___No **Multiple Sclerosis**
___Yes ___No **Pain Management**
___Yes ___No **Psychiatric Treatment**
___Yes ___No **Shingles**
___Yes ___No **Sinus Problems**
___Yes ___No **Stroke**
___Yes ___No **Thyroid Disease**
___Yes ___No **Tobacco Use**
Daily use_____
___Yes ___No **Ulcers**
___Yes ___No **Venereal D**

**Please list all past/recent surgeries**_____

_____

**Please list any other conditions not listed above**

_____

_____

To the best of my knowledge, the information on both sides of this form is correct and true. I understand that my health history information is necessary for diagnosis and treatment.

_____

Signature of Patient/Guardian Date