Dental History

Reason for today's visit: _____

How often do you brush? _____ Floss? _____

Approximate date of last dental visit: _____

Please mark all that apply:

- ☐ TOOTHACHE Where: _____
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN TEETH
- ☐ FOOD CATCHES
- ☐ FLOSS BREAKS OR HURTS
- ☐ CLICKING OR POPPING OF JAW
- ☐ GRINDING OF TEETH
- ☐ CLENCHING OF TEETH
- ☐ HEADACHES
- ☐ SINUS PROLEMS
- ☐ DO YOU SNORE
- ☐ PREVIOUS SLEEP EVALUATION
- ☐ DRY MOUTH IN MORNING
- ☐ GAG EASILY
- ☐ SENSITIVITY
  - ☐ COLD
  - ☐ HOT
  - ☐ SWEET
  - ☐ CHEWING
  - ☐ TOUCH
- ☐ GUMS BLEED
- ☐ GUMS TENDER OR SORE
- ☐ TEETH SHIFTED
- ☐ BAD BREATHE
- ☐ BAD TASTE
- ☐ SORES IN MOUTH
- ☐ OTHER _____
- ☐ OTHER _____
- ☐ OTHER _____

Health History

Mark all that apply: ☐ HOSPITALIZED ☐ TAKING MEDICATION ☐ ALLERGIES ☐ ILLNESSES

Please describe: _____

_____

_____

_____

- ☐ *PRE-MED _____
- ☐ ALLERGY _____
- ☐ ACID REFLUX
- ☐ ANEMIA
- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS - When: _____
- ☐ ASTHMA
- ☐ BACK PROBLEMS
- ☐ BISPHOSPHATE MEDICATION (Fosamax, Acetol, Atelviz, Didronel, Boniva)
- ☐ BLEEDING DISORDERS
- ☐ BLOOD PRESSURE HIGH / LOW
- ☐ BLOOD THINNERS
- ☐ BLOOD DISEASE
- ☐ BLOOD TRANSFUSION
- ☐ CANCER _____
- ☐ CHEMICAL / DRUG DEPENDENCIES
- ☐ CHEMO THERAPY
- ☐ CIRCULATORY PROBLEMS
- ☐ CORTISONE TREATMENT
- ☐ DEMENTIA
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIZZINESS
- ☐ EPILEPSY
- ☐ FAINTING
- ☐ GLAUCOMA
- ☐ HEAD INJURIES
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEART PROBLEMS
- ☐ HEMOPHILIA
- ☐ HEPATITIS ☐ A ☐ B ☐ C
- ☐ HIV / AIDS
- ☐ IMPOTENCE
- ☐ INSOMNIA
- ☐ JAUNDICE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MARIJUANA USAGE
- ☐ MENTAL HEALTH ISSUES
- ☐ MITRAL VALVE PROLAP
- ☐ NERVOUS DISORDERS
- ☐ NURSING
- ☐ OBESITY
- ☐ PACEMAKER
- ☐ PERSISTENT COUGH
- ☐ PREGNANT
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SHORTNESS OF BREATH
- ☐ SINUS PROBLEMS
- ☐ SLEEP APNEA
- ☐ STOMACH PROBLEMS
- ☐ STROKE
- ☐ SWELLING FEET / ANKLES
- ☐ THYROID CONDITION
- ☐ TOBACCO USAGE
- ☐ TONSILLITIS
- ☐ TUBERCULOSIS
- ☐ TUMORS
- ☐ TROUBLE SLEEPING
- ☐ ULCERS
- ☐ OTHER _____

Physician's Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

_____

PATIENT / PARENT or GUARDIAN SIGNATURE PRINTED NAME DATE

_____

DR'S SIGNATURE DATE