

# DENTAL HEALTH HISTORY

Confidential

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First Initial

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

- |   |   |
|---|---|
| Yes No  | Yes No  |
| <input type="checkbox"/> <input type="checkbox"/> Are you having pain or discomfort at this time? | <input type="checkbox"/> <input type="checkbox"/> Have you had any problems with your jaw?            |
| <input type="checkbox"/> <input type="checkbox"/> Do your gums bleed when you brush?              | <input type="checkbox"/> <input type="checkbox"/> Do you clench or grind your teeth?                  |
| <input type="checkbox"/> <input type="checkbox"/> Do you have a history of gum disease?           | <input type="checkbox"/> <input type="checkbox"/> Do you wear a denture, partial, or retainer?        |
| <input type="checkbox"/> <input type="checkbox"/> Are you nervous about receiving dental care?    | <input type="checkbox"/> <input type="checkbox"/> Have you had a bad experience in the dental office? |
| <input type="checkbox"/> <input type="checkbox"/> Do you have any lumps in or near your mouth?    | <input type="checkbox"/> <input type="checkbox"/> Do you use tobacco products?                        |
| <input type="checkbox"/> <input type="checkbox"/> Have you had any head, neck, or jaw injuries?   | <input type="checkbox"/> <input type="checkbox"/> Do you like your SMILE?                             |

## MEDICAL HISTORY

**Women:** Are you pregnant?  Yes  No      Nursing?  Yes  No      Taking birth control pills?  Yes  No  
Are you aware that antibiotics can decrease the effectiveness of birth control?  Yes  No

Check (✓) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Recreational Drug Use | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcer                      |

Please list any disease, condition, or special need not listed: \_\_\_\_\_

### MEDICATIONS / HERBAL REMEDIES

Please list any medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Pharmacy \_\_\_\_\_

### ALLERGIES

- |  |  |
|--|--|
| <input type="checkbox"/> Aspirin / Ibuprofen | <input type="checkbox"/> Penicillin              |
| <input type="checkbox"/> Codeine             | <input type="checkbox"/> Sedatives               |
| <input type="checkbox"/> Iodine              | <input type="checkbox"/> Sulfa                   |
| <input type="checkbox"/> Latex               | <input type="checkbox"/> Other _____             |
| <input type="checkbox"/> Local Anesthetic    | <input type="checkbox"/> No known drug allergies |

## SIGNATURE

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.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient