DENTAL HEALTH HISTORY

REASON FOR VISIT ❑ Checkup ❑ Cleaning ❑ Toothache ❑ Other _____

When did you last visit a dentist? _____ What treatment was performed? _____

Was the treatment completed? ❑ Yes ❑ No Did you have xrays taken? ❑ Yes ❑ No

Did you have a cleaning? ❑ Yes ❑ No Are your teeth sensitive to hot or cold? ❑ Yes ❑ No

Do your gums bleed easily? ❑ Yes ❑ No Have you had gum (periodontal) treatment? ❑ Yes ❑ No

Have you had any trouble with past dental treatment? ❑ Yes ❑ No If yes, explain: _____

Have you ever had prolonged bleeding after an extraction/treatment? ❑ Yes ❑ No If yes, explain: _____

Do you grind your teeth, clinch your jaws or have symptoms near your ears such as clicking, popping, pain or locking? ❑ Yes ❑ No

If yes, explain: _____

Have you ever been treated for TMD (Temporomandibular Joint Dysfunction) or TMJ? ❑ Yes ❑ No

Do you feel you have bad breath? ❑ Yes ❑ No

Would you like your teeth whiter? ❑ Yes ❑ No

Are you happy with your smile? ❑ Yes ❑ No

If no, explain: _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever
- ❑ Joint replacement
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Heart Condition (heart attack, stroke, etc)

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following? (Please check any that apply)

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other: _____

Are you taking any medication? ❑ Yes ❑ No

Please List: _____

_____

_____

_____

_____

Females: (Please check any that apply)

- ❑ May be pregnant:
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives
- ❑ Nursing

EMERGENCY CONTACT INFORMATION

In case of emergency, contact:

Name _____ Phone _____

Name of your physician: _____ Phone _____

I have answered all questions to the best of my knowledge. I will inform the dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**