DENTAL HISTORY

General Dentist _____ Date of last dental visit: _____
Referred By _____ Date of last x-rays: _____
Have you experienced or are you experiencing any of the following:

- □ Bad Breath
- □ Bleeding Gums
- □ Clicking/popping of jaw
- □ Food collection between teeth
- □ Grinding Teeth
- □ Loose or broken fillings
- □ Periodontal treatment
- □ Sores or growths in mouth
- □ Sensitivity to cold
- □ Sensitivity to hot
- □ Sensitivity to sweets
- □ Sensitivity when biting

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

MEDICAL HISTORY

Are you currently under the care of a physician: □ Yes □ No Physician Name: _____
Are you currently being treated for any condition: □ Yes □ No Date of last visit: _____

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

- □ AIDS or related disease
- □ Artificial Heart Valves
- □ Artificial Joints
- □ Autism, Asperger's or Cerebral Palsy
- □ Blood Disorders (anemia, etc.)
- □ Blood Transfusion
- □ Cancer
- □ Cardiovascular Disease (heart disease, heart attack, stroke, etc.)
- □ Chemotherapy
- □ Chronic Sinus Trouble
- □ Circulatory Problems
- □ Chemical Dependency
- □ Others _____
- □ Congenital heart lesions or murmur
- □ Cortisone Treatments
- □ Diabetes
- □ Epilepsy, seizures, ADD, ADHD
- □ Fainting
- □ Glaucoma
- □ Hepatitis
- □ Inflammatory Rheumatism (Arthritis, swollen joints, etc.)
- □ Kidney Disease
- □ Liver Disease, jaundice
- □ Mitral Valve Prolapse
- □ Headaches
- □ Persistent Cough
- □ Pregnant or Nursing
- □ Psychiatric Care
- □ Respiratory Illness (Asthma, COPD, Tuberculosis, etc.)
- □ Rheumatic Fever
- □ Radiation Therapy
- □ Skin Rash
- □ STDs
- □ Tobacco Habit
- □ Thyroid Problem
- □ Ulcers

Have you ever had abnormal bleeding with previous surgery, extractions, or trauma? ..... □ Yes □ No
Have you had general anesthesia for surgery before? ..... □ Yes □ No

Are you allergic to or have reacted adversely to any of the following?

- □ Local Anesthetics
- □ Penicillin
- □ Sulfa
- □ Antidepressants (sleeping pills)
- □ Aspirin
- □ Codeine
- □ Latex
- □ Other

Please list all other medications you are allergic to:
_____
_____
_____

Are you taking any of the following medications?

- □ Aspirin
- □ Blood Thinners (Coumadin, Plavix, etc.)
- □ Birth Control Pills
- □ Osteoporosis/Bisphosphonates (Fosamax, Didronel, Boniva, Skelid, Reclast, Aredia, Actonel, Zometa, etc)

Please list all current medications:
_____
_____
_____
_____
_____
_____

Pharmacy Name _____
Phone Number _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.
Date _____ Signature _____