Dental History

Date _____

Patient Name _____ Date of Birth _____ Age _____

Reason for visit _____ Other _____

Do you have any health conditions we should be aware of? ☐ Yes ☐ No _____

Date of last visit to a dentist _____ Treatment performed _____

Was the treatment completed? _____ When were dental x-rays taken? _____

Did you have a cleaning? ☐ Yes ☐ No Have you had periodontal (gum) treatment? ☐ Yes ☐ No

Please check the following apply to you:

- ☐ Problems with past dental treatment
- ☐ Bleeding after extraction
- ☐ Teeth grinding
- ☐ Jaw clinching
- ☐ Ear problems (including popping, locking, pain and clicking)
- ☐ Temporomandibular Joint Dysfunction (TMJ)

MEDICAL INFORMATION

Are you under a doctor's care? ☐ Yes ☐ No

If yes, please specify _____ Doctor's Name _____ Phone # _____

Are you allergic to penicillin, local anesthetics, tranquilizer, codeine or any other medicine? _____

Are you currently taking any medications (inc. birth control? If yes, specify) _____

Are you pregnant? If so, how many months? _____

Do you have other health problems we should be aware of? _____

Please check if you have any of the following:

- ☐ Artificial heart valve
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding problems
- ☐ Cancer
- ☐ Chemo/ rad therapy
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Dizziness or fainting
- ☐ Drug addiction
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart surgery
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Jaundice
- ☐ Joint replacement
- ☐ Kidney disease
- ☐ Latex allergy
- ☐ Liver problems
- ☐ Low blood pressure
- ☐ Lung disease
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Sinus trouble
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Others _____

*** *I have answered every question completely and accurately to the best of my knowledge. I will inform my dentist of changes in my health and/or medication. I certify that I consent to taking-rays and an oral examination.*

Signature of Patient or Responsible party _____ Date _____ Signature of Doctor _____
(Parent is patient is minor)

MEDICAL UPDATE

Patient Signature _____ Doctor Signature _____ Date _____

Patient Signature _____ Doctor Signature _____ Date _____