

## Dental History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Former Dentist: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Date of last exam: \_\_\_\_\_ Date of last dental X-rays: \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Please check any of the following that apply to you:

- |  |   |  |
|--|---|--|
| 1. <input type="checkbox"/> Bad breath               | 2. <input type="checkbox"/> Dental Fear                     | 3. <input type="checkbox"/> Sensitivity to cold        |
| 4. <input type="checkbox"/> Bleeding gums            | 5. <input type="checkbox"/> Grinding Teeth                  | 6. <input type="checkbox"/> Sensitivity to hot         |
| 7. <input type="checkbox"/> Broken teeth or fillings | 8. <input type="checkbox"/> Sore jaw muscles                | 9. <input type="checkbox"/> Sensitivity to sweets      |
| 10. <input type="checkbox"/> Loose teeth             | 11. <input type="checkbox"/> Clicking or popping jaw        | 12. <input type="checkbox"/> Sensitivity to bite       |
| 13. <input type="checkbox"/> Periodontal treatment   | 14. <input type="checkbox"/> Sores or growths in your mouth | 15. <input type="checkbox"/> Take fluoride supplements |

Have experienced unfavorable dental treatment

Have experienced breathing laughing gas (nitrous oxide) with your dental treatment

*Would prefer* using laughing gas (nitrous oxide) with your dental treatment

Need to take antibiotic prophylaxis before dental treatment

Have experienced a reaction to penicillin, dental anesthetic or other

*Please specify and describe:* \_\_\_\_\_

## Medical History

Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

List of current medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

Women:            Are you pregnant? Y / N            Nursing? Y / N            Taking birth control pills? Y / N

Please check any of the following conditions you currently have or have had in the past:

- |  |  |  |   |
|--|--|--|---|
| 1. <input type="checkbox"/> AIDS                     | 2. <input type="checkbox"/> Diabetes             | 3. <input type="checkbox"/> HIV Positive           | 4. <input type="checkbox"/> Rheumatic Fever   |
| 5. <input type="checkbox"/> Alcoholism               | 6. <input type="checkbox"/> Epilepsy             | 7. <input type="checkbox"/> Kidney Disease         | 8. <input type="checkbox"/> Sinus Trouble     |
| 9. <input type="checkbox"/> Anemia                   | 10. <input type="checkbox"/> Fainting            | 11. <input type="checkbox"/> Liver Disease         | 12. <input type="checkbox"/> Stroke           |
| 13. <input type="checkbox"/> Arthritis               | 14. <input type="checkbox"/> Glaucoma            | 15. <input type="checkbox"/> Mitral Valve Prolapse | 16. <input type="checkbox"/> Thyroid Problems |
| 17. <input type="checkbox"/> Artificial Heart Valves | 18. <input type="checkbox"/> Heart Murmur        | 19. <input type="checkbox"/> Pacemaker             | 20. <input type="checkbox"/> Tobacco Habit    |
| 21. <input type="checkbox"/> Artificial Joints       | 22. <input type="checkbox"/> Heart Problems      | 23. <input type="checkbox"/> Prolonged Bleeding    | 24. <input type="checkbox"/> Tonsillitis      |
| 25. <input type="checkbox"/> Asthma                  | <i>describe</i> _____                            |  |   |
| 26. <input type="checkbox"/> Back Problems           |  |  |   |
| 27. <input type="checkbox"/> Blood Disease           | 28. <input type="checkbox"/> Hemophilia          | 29. <input type="checkbox"/> Psychiatric Care      | 30. <input type="checkbox"/> Tumor            |
| 31. <input type="checkbox"/> Cancer                  | 32. <input type="checkbox"/> Hepatitis           | 33. <input type="checkbox"/> Radiation Treatment   | 34. <input type="checkbox"/> Ulcer            |
| 35. <input type="checkbox"/> Chemotherapy            | 36. <input type="checkbox"/> High Blood Pressure | 37. <input type="checkbox"/> Respiratory Disease   | 38. <input type="checkbox"/> Venereal Disease |

39.  Other: \_\_\_\_\_