Patient Dental History

Name of Previous Dentist — Date of Last Exam
Previous Dentist's Location — Date of Last Cleaning

1. Do your gums bleed while brushing	Yes	No	8. Have you ever experienced any of the		
2. Do your gums bleed while flossing?	Yes	No	following problems with your jaw?		
3. Are your teeth sensitive to hot or cold?	Yes	No	a. Clicking	Yes	No
4. Do you have frequent headaches?	Yes	No	b. Pain (joint, ear, side of face)	Yes	No
5. Do you clench or grind your teeth?	Yes	No	c. Difficulty in opening or closing	Yes	No
6. Are your teeth sensitive to sweets or sours?	Yes	No	d. Difficulty in chewing	Yes	No
7. Do you feel pain to any of your teeth?	Yes	No	9. Do you like your smile	Yes	No

Please check if you have had a problem with any of the following:

__ Bad Breath __ Loose Tooth __ Broken Fillings __ Growths in Mouth
__ Sore in Mouth __ Periodontal Treatment __ Food caught Between Teeth __ Other _____

How often do you Brush? How often do you Floss?

Patient Medical History

Physician's Name — Date of Last Visit
Have you had any serious illnesses or operations Yes No If Yes, describe
Have you ever had a blood transfusion? Yes No If Yes, appr. Date

Please Circle YES or NO:

AIDS or HIV infection	Yes	No	Diabetes	Yes	No			
Angina	Yes	No	Epilepsy	Yes	No	Hepatitis	Yes	No
Anemia	Yes	No	Fainting	Yes	No	Scarlet Fever	Yes	No
Arthritis, Rheumatism	Yes	No	Glaucoma	Yes	No	Shortness of Breath	Yes	No
Artificial Heart Valves	Yes	No	Headaches	Yes	No	Skin Rash	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Heart Problems	Yes	No	If yes, When _____		
Back Problems	Yes	No	Describe _____			Swelling of Feet	Yes	No
Blood Disease	Yes	No	Hemophilia	Yes	No	Thyroid Problem	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Tonsillitis	Yes	No
Cardiac Pacemaker	Yes	No	Kidney Disease	Yes	No	Tuberculosis	Yes	No
Chemical Dependency	Yes	No	Liver Disease	Yes	No	Ulcer	Yes	No
Chemotherapy	Yes	No	Leukemia	Yes	No	Sinus Problems	Yes	No
Mitral Valve Prolapsed	Yes	No	Nervous Problems	Yes	No	Venereal Disease	Yes	No
Chest Pain	Yes	No	Psychiatric Care	Yes	No	Heart Attack	Yes	No
Circulatory Problems	Yes	No	Radiation Treatment	Yes	No	If yes, when _____		
Cortisone Treatments	Yes	No	Respiratory Disease	Yes	No	Others	Yes	No
Cough, Persistent	Yes	No	Rheumatic Fever	Yes	No	If yes, describe _____		

Do you have any Allergies? Yes No If yes, what?
Do you need to take a Pre-Medication or antibiotic before dental treatment? Yes No
Do you feel you are in good health? Yes No
Please list any and all medication you are taking._____

_____

_____

Do you use Tobacco? Yes No Do you use controlled substances? Yes No

Women ONLY

Are You Pregnant *Yes* *No* *Nursing?* *Yes* *No* *Taking Birth Control Pills?* *Yes* *No*

Patient Signature ***Date***