Dental Health History

Basic Information

Patient Name	Date of Birth	Email
Address		Contact Number

Dental History

Reason for Today's Visit

Former Dentist Name		Email	Contact Number
Date of Last Dental Care	Date of Last Dental X-rays	Flossing Frequency	Brushing Frequency

Select any of the following problems you have or have had

- o Bad Breath
- o Bleeding Gums
- o Clicking or Popping Jaw
- o Food Collection Between Teeth
- o Grinding Teeth
- o Loose Teeth or Broken Fillings
- o Periodontal Treatment
- o Sensitivity to Cold
- o Sensitivity to Hot
- o Sensitivity to Sweets
- o Sensitivity when Biting
- o Sores or Growths in Your Mouth

Medical History

Physician Name	Email	Date of Last Visit

Have you ever had a blood transfusion? o Yes o No If yes, what was the approximate date:

Are you pregnant? o Yes o No Nursing? o Yes o No Taking birth control pills? o Yes o No

Select any of the following that you have or have had

- o Anemia
- o Arthritis, Rheumatism
- o Artificial Heart Valves
- o Artificial Joints
- o Asthma
- o Back Problems
- o Blood Disease
- o Cancer
- o Chemical Dependency
- o Chemotherapy
- o Circulatory Problems
- o Cortisone Treatments
- o Persistent Cough
- o Cough up Blood
- o Diabetes
- o Epilepsy
- o Fainting
- o Glaucoma
- o Headaches
- o Heart Murmur
- o Heart Problems
- o Hemophilia
- o Hepatitis
- o High Blood Pressure
- o HIV/AIDS
- o Jaw Pain
- o Kidney Disease
- o Liver Disease
- o Mitral Valve Prolapse
- o Pacemaker
- o Radiation Treatment
- o Respiratory Disease
- o Rheumatic Fever
- o Scarlet Fever
- o Shortness of Breath
- o Skin Rash
- o Stroke
- o Swelling of Feet or Ankles
- o Thyroid Problems
- o Tobacco Habit
- o Tonsillitis
- o Tuberculosis
- o Ulcer
- o Venereal Disease

List any other serious illnesses or operation that you have or have had

List any current medications	List any allergies

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.

Parent, Guardian or Personal Representative Name (Printed)	Relationship to Patient (If Applicable)
Signature of Patient, Parent, Guardian or Personal Representative	Date