

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 <input type="checkbox"/> Bad Breath <input type="checkbox"/> Grinding Teeth <input type="checkbox"/> Sensitivity to Hot <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Loose Teeth or Broken Fillings <input type="checkbox"/> Sensitivity to Sweets <input type="checkbox"/> Clicking or Popping Jaw <input type="checkbox"/> Periodontal Treatment <input type="checkbox"/> Sensitivity when Biting <input type="checkbox"/> Food Collection Between Teeth <input type="checkbox"/> Sensitivity to Cold <input type="checkbox"/> Sores or Growths in Your Mouth			
Medical History			
Physician Name		Email	Date of Last Visit
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what was the approximate date:			
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No Taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Select any of the following that you have or have had <input type="checkbox"/> Anemia <input type="checkbox"/> Cortisone Treatments <input type="checkbox"/> Hepatitis <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Arthritis, Rheumatism <input type="checkbox"/> Persistent Cough <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Artificial Heart Valves <input type="checkbox"/> Cough up Blood <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Skin Rash <input type="checkbox"/> Artificial Joints <input type="checkbox"/> Diabetes <input type="checkbox"/> Jaw Pain <input type="checkbox"/> Stroke <input type="checkbox"/> Asthma <input type="checkbox"/> Epilepsy <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Swelling of Feet or Ankles <input type="checkbox"/> Back Problems <input type="checkbox"/> Fainting <input type="checkbox"/> Liver Disease <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Blood Disease <input type="checkbox"/> Glaucoma <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Tobacco Habit <input type="checkbox"/> Cancer <input type="checkbox"/> Headaches <input type="checkbox"/> Pacemaker <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Heart Problems <input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Ulcer <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> Hemophilia <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> 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