

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