**Patient** _____ **D.O.B.** _____

**DENTAL HISTORY**

*Place a mark on "yes" or "no" to indicate if you or your child have had any of the following:*

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Bad breath | | | How often do you floss? | | |
| Bleeding gums | | | Jaw pain or tiredness | | |
| Blisters on lips or mouth | | | Lip or cheek biting | | |
| Burning sensation on tongue | | | Loose teeth or broken fillings | | |
| Chew on one side of mouth | | | Mouth breathing | | |
| Cigarette, pipe or cigar smoking | | | Mouth pain, brusing | | |
| Clicking or popping jaw | | | Previous orthodontic treatment | | |
| Dry mouth | | | Pain around ear | | |
| Fingernail biting | | | Periodontal treatment | | |
| Food collection between the teeth | | | Sensitivity to cold | | |
| Foreign objects | | | Sensitivity to heat | | |
| Grinding teeth | | | Sensitivity to sweets | | |
| Gums swollen or tender | | | Sensitivity when biting | | |
| How often do you brush? | | | Sores or growths in your mouth | | |

**HEALTH HISTORY**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| AIDS/HIV | | | Low blood pressure | | |
| Anemia | | | Mitral valve prolapse | | |
| Arthritis, rheumatism | | | Nervous problems | | |
| Artificial heart valves | | | Pacemaker | | |
| Artificial joints | | | Psychiatric care | | |
| Asthma | | | Radiation treatment | | |
| Back problems | | | Respiratory disease | | |
| Bleeding abnormally, with extractions or surgery | | | Rheumatic fever | | |
| Blood disease | | | Scarlet fever | | |
| Cancer | | | Shortness of breath | | |
| Chemical dependency | | | Sinus trouble | | |
| Chemotherapy | | | Skin rash | | |
| Circulatory problems | | | Special diet | | |
| Congenital heart lesions | | | Stroke | | |
| Cortisone treatments | | | Swollen feet or ankles | | |
| Cough, persistent or bloody | | | Swollen neck glands | | |
| Diabetes | | | Thyroid problems | | |
| Emphysema | | | Tonsillitis | | |
| Epilepsy | | | Tuberculosis | | |
| Fainting or dizziness | | | Tumor or growth on head or neck | | |
| Glaucoma | | | Ulcer | | |
| Headaches | | | Venereal disease | | |
| Heart murmur | | | Weight loss, unexplained | | |
| Heart problems | | | Are you taking Bisphosphonates? | | |
| Hepatitis type _____ | | | (Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia or Zometa) | | |
| Herpes | | | Do you wear contact lenses? | | |
| High blood pressure | | | *WOMEN:* | | |
| Jaundice | | | Are you pregnant? | | |
| Jaw pain | | | If so, due date _____ | | |
| Kidney disease | | | Taking birth control pills? | | |
| Liver disease | | | Are you nursing? | | |

MEDICATIONS

| List any medications you are currently taking: | *ALLERGIES:* | |
|---|---|---|
| | □ Aspirin | □ Latex |
| | □ Barbiturates (sleeping pills) | □ Local anesthetic |
| Pharmacy name | □ Codeine | □ Penicillin |
| Pharmacy phone number | □ Iodine | □ Sulfa |

UPDATES

| Changes | Date | Patient's or parent's signature |
|---|---|---|
| | | |
| | | |

I certify that the above questions have been accurately answered.
I understand that providing incorrect or insufficient information can be dangerous to my (or my child's) health.

_____ _____ _____

**Patient's or Parent's Signature** **Date** Doctor Reviewed