Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Dental History

What is the reason for this appointment? _____

Are there any specific dental problems we should know about? _____

Are you aware of any decay or cavities?	YES	NO	How often do you floss? _____
Do you suffer from consistent bad breath or bad taste?	YES	NO	How often do you brush? _____
Do you have any jaw cracking or pain?	YES	NO	Texture of your toothbrush? _____
Do you clench or grind you teeth?	YES	NO	When was your last cleaning? _____
Have you had periodontal treatment?	YES	NO	When were the last x-rays taken? _____
Have you had orthodontic treatment?	YES	NO	Name of your previous dentist? _____
How would you describe your dental health?	EXCELLENT	GOOD	FAIR POOR

Medical History *please circle yes or no*

ANY HEART PROBLEMS	YES	NO
HEART ATTACK	YES	NO
ANGINA	YES	NO
BYPASS	YES	NO
PACEMAKER	YES	NO
STROKE	YES	NO
HIGH BLOOD PRESSURE	YES	NO
LOW BLOOD PRESSURE	YES	NO
HEART MURMUR	YES	NO
MITRAL VALVE PROLAPSE	YES	NO
HEART VALVE DEFECT	YES	NO
HEART VALVE REPLACEMENT	YES	NO
RHEUMATIC FEVER	YES	NO
BLEEDING DISORDER	YES	NO
ANEMIA	YES	NO
HEMOPHILIA	YES	NO
SICKLE CELL TRAIT	YES	NO
BLOOD TRANSFUSION	YES	NO
ARTIFICIAL JOINT	YES	NO

DO YOU SMOKE?	YES	NO
LUNG/BREATHING PROBLEMS	YES	NO
ASTHMA	YES	NO
BRONCHITIS	YES	NO
EMPHYSEMA	YES	NO
TUBERCULOSIS	YES	NO
SINUS TROUBLE	YES	NO
DIABETES	YES	NO
DIFFICULTY HEALING	YES	NO
LIVER PROBLEMS	YES	NO
HEPATITIS/JAUNDICE	YES	NO
KIDNEY PROBLEMS	YES	NO
STOMACH TROUBLE/ULCERS	YES	NO
ALCOHOLISM	YES	NO
DRUG ABUSE	YES	NO
NERVOUS/MENTAL DISORDER	YES	NO
EPILEPSY/SEIZURES	YES	NO
THYROID PROBLEMS	YES	NO
ADRENAL/PITUITARY	YES	NO

ALLERGIC REACTION (HIVES/SWELLING):		
PENICILLIN	YES	NO
ERYTHROMYCIN	YES	NO
SULFA	YES	NO
CODEINE	YES	NO
ASPRIN	YES	NO
ANESTHETIC	YES	NO
LATEX	YES	NO
OTHER _____		
INFECTIOUS DISEASES	YES	NO
HIV/AIDS	YES	NO
CANCER/TUMOR	YES	NO
GROWTHS	YES	NO
CHEMOTHERAPY	YES	NO
RADIATION	YES	NO
ARE YOU PREGNANT	YES	NO
HOW MANY MONTHS? _____		

Do you need to take antibiotic pre-medication prior to dental appointments?	YES	NO	Why? _____
Do you have any current health problems not listed above?	YES	NO	What? _____
Is a physician currently treating you?	YES	NO	Why? _____
Are you presently taking medications, pills, or tonics?	YES	NO	

Please list: _____

Physician's name: _____ Phone Number: _____

MEDICAL HISTORY REVIEWED: _____ Date: _____