Dental History

Patient Name: ________________________________

How frequently do you brush? ____________________

How frequently do you floss? ________________

Are you aware of any growths in your mouth? □ Yes □ No

Do your gums bleed? □ Yes □ No

Do you want to change the appearance of your smile? □ Yes □ No

Do you have a dry mouth? □ Yes □ No

Have you had any periodontal (gum) treatment? □ Yes □ No

Are your teeth sensitive? □ Yes □ No

Do you frequently get canker sores? □ Yes □ No

Frequent cold sores? □ Yes □ No

Pain in jaw joints? □ Yes □ No

Are you apprehensive about dental visits? □ Yes □ No

If apprehensive, what can we do to improve your visit? ____

Medical History

Medical Doctor: __________________________ Phone: _________________ City: ______________________

1. Have you been hospitalized or had a major operation? □ Yes □ No ________________________________
2. Have you had a serious head or neck injury? □ Yes □ No ____
3. Are you taking any medications or supplements and for what reason? □ Yes □ No _____________________
   ____
4. Have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? □ Yes □ No
5. Do you vape or use tobacco? □ Yes □ No If so, type/ frequency: ___________________________________
6. Do you require a premed for dental visits? □ Yes □ No ____

Women only: Are you….

□ Pregnant/ Trying to get pregnant? Wk: ______ □ Nursing? □ Taking oral contraceptives?

Are you allergic or had an anaphylactic reaction to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic

□ Localized Anesthetics □ Sulfa Drugs □ Latex □ Metal

□ Other? ________________________________

Do you have, or have you had any of the following?

AIDS/ HIV positive	□ Yes □ No	Diabetes Type 2	□ Yes □ No	HPV/other venereal disease	□ Yes □ No
Alzheimer's Disease	□ Yes □ No	Drug or Alcohol Abuse	□ Yes □ No	Kidney Problems	□ Yes □ No
Anemia	□ Yes □ No	Emphysema or COPD	□ Yes □ No	Liver Disease	□ Yes □ No
Arthritis/ Gout	□ Yes □ No	Epilepsy or Seizures	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Excessive Bleeding	□ Yes □ No	Mental Health Condition	□ Yes □ No
Artificial Joint	□ Yes □ No	Excessive Thirst	□ Yes □ No	MRSA	□ Yes □ No
Auto Immune Disease	□ Yes □ No	Fainting Spells/ Dizziness	□ Yes □ No	Osteoporosis	□ Yes □ No
Asthma	□ Yes □ No	Frequent Headaches	□ Yes □ No	Shingles	□ Yes □ No
Blood Disease	□ Yes □ No	Glaucoma	□ Yes □ No	Sickle Cell Disease	□ Yes □ No
Cancer	□ Yes □ No	High Blood Pressure	□ Yes □ No	Sinus Troubles	□ Yes □ No
Chemo/ Radiation	□ Yes □ No	Heart Trouble/Disease	□ Yes □ No	Stroke	□ Yes □ No
Chest pains	□ Yes □ No	Hepatitis B	□ Yes □ No	Thyroid Disease	□ Yes □ No
Congenital Heart Disorder	□ Yes □ No	Hepatitis C	□ Yes □ No	Tuberculosis	□ Yes □ No
Developmental Disability	□ Yes □ No	High Cholesterol	□ Yes □ No	Ulcers or acid reflux	□ Yes □ No
Diabetes Type 1	□ Yes □ No				

If yes to any of the above, please explain: ____

Any other disease, condition or problems not listed? ____