# Dental Health History

Previous Dentist: _____ Date of Last Dental Visit: _____

Have you ever received bisphosphonate drugs? If so, when?: _____

Have you ever had periodontal (gum) treatment/surgery? If so, when?: _____

Please check any of the following which apply.

- ☐ You have apprehension about dental treatment
- ☐ You have had problems with previous dental treatment
- ☐ You gag easily
- ☐ You wear dentures
- ☐ Food catches between your teeth
- ☐ You have difficulty chewing food
- ☐ Due to pain, you chew on only one side of your mouth
- ☐ Your gums bleed easily
- ☐ Your gums bleed when you floss
- ☐ Your gums feel swollen or tender
- ☐ You have had slow-healing sores in or about your mouth
- ☐ You have sensitive teeth

You experience twinges of pain when you eat or drink:

- ☐ Hot foods or liquids
- ☐ Cold foods or liquids
- ☐ Sours
- ☐ Sweets
- ☐ Other: _____

- ☐ You take fluoride supplements
- ☐ You are dissatisfied with your teeth's appearance
- ☐ You prefer to save your teeth
- ☐ You want complete dental care

How often do you brush? _____

How often do you floss? _____

- ☐ Your jaw makes noise which bothers you or others
- ☐ You clench or grind your jaw frequently
- ☐ Your jaw feels tired
- ☐ Your jaw gets stuck so that you can't open it freely
- ☐ It hurts when you chew
- ☐ It hurts when you open wide to take a bite
- ☐ You have earaches or pain in front of the ears
- ☐ Jaw symptoms or headaches when you wake
- ☐ Jaw pain or discomfort which affects appetite, sleep, daily routine, or other activities
- ☐ Jaw pain or discomfort that is easily frustrating or depressing
- ☐ You take medication or pills for pain or discomfort – such as pain relievers, muscle relaxants, or antidepressants
- ☐ Temporomandibular (Jaw) Disorder – TMJ
- ☐ Pain in the face, cheeks, jaws, joints, throat, or temples
- ☐ Inability to open your mouth as far as you would want
- ☐ You have an uncomfortable bite
- ☐ You have had a blow (trauma) to the jaw
- ☐ You are a habitual gum chewer
- ☐ You use tobacco products (chew or smoke)

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

# Medical Health History

Please check any of the following which you have or have had.

- ☐ AIDS
- ☐ Do you drink alcohol? If so, how often? _____
- ☐ Allergies: _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Do you carry an inhaler?
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cold Sores/Fever Blisters
- ☐ Contact Lenses
- ☐ Cortisone Medication
- ☐ Cough or Swollen Glands
- ☐ Diabetes
- ☐ Diet (Special/Restricted)
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ H.I.V. Positive
- ☐ Head Injuries
- ☐ Heart Problems (Attack, Disease, Surgery)
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Latex Sensitivity
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due Date: _____
- ☐ Psychiatric or Psychological Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Urinate 6 or more times a day
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Allergic/Adverse Reaction To Medication or Any Substance; Please Specify: _____ _____
- ☐ Other: _____
- ☐ Pre-Medication Needed Why? _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No

Name of physician and reason: _____

Do you have health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

Please list all the medications you are taking: _____

During the past 12 months, have you taken any drugs other than the ones you have listed? ☐ Yes ☐ No

**To the best of my knowledge, all of the preceding answers and information provided are true and correct.**
**If I ever have any change in my health, I will inform Doctor at the next appointment.**

Signature of patient or guardian: _____ Date: _____

Signature of Doctor: _____ Date: _____