"The Beginning of Your New Smile"

Dental History

What would you like us to do today? ____
Are you in dental discomfort today? ____
Former Dentist ________________________ Address ______________________________
Phone ____________________________ Dentist's Email ____________________________
Date of last care ________________________________ Date of last X-rays ____________________

Check Y for yes or N for no if you have or have not had the following:

__ Y __ N Bad breath
__ Y __ N Food collection between teeth
__ Y __ N Periodontal treatment
__ Y __ N Sensitivity to sweets
__ Y __ N Bleeding gums
__ Y __ N Grinding or clenching teeth
__ Y __ N Sensitivity to cold
__ Y __ N Sensitivity when biting
__ Y __ N Clicking or popping jaw
__ Y __ N Loose teeth or broken fillings
__ Y __ N Sensitivity to hot
__ Y __ N Sores or growths in mouth

How often do you brush? ______________________ How often do you floss? ___________________
How do you feel about the appearance of your teeth? ____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?
__ Y __ N Please explain____

Medical History

Physician's Name __________________ Address ____
Phone ____________________ Email ____
Date of last visit ________ Have you had any serious illnesses or operations? __ Y __ N
If yes, describe ____
Are you currently under physician care? __ Y __ N If yes, describe ___________________________
Have you ever had a blood transfusion? __ Y __ N If yes, give approx. date(s) __________________
Do you or **have you ever** taken bisphosphonate medications for osteoporosis, cancer, or multiple myeloma such as (Fosamax, Actonel, Boniva, Reclast, Aredia, or Zometa)? __ Y __ N If so, for how long (months or years) ________
Women: Are you pregnant? __ Y __ N Nursing? __ Y __ N Taking birth control? __ Y __ N

Check **Y** for yes or **N** for no if you have or have not had the following:

__ Y __ N AIDS/HIV Positive
__ Y __ N Anaphylaxis
__ Y __ N Anemia
__ Y __ N Arthritis, Rheumatism
__ Y __ N Artificial heart valves
__ Y __ N Artificial joints
__ Y __ N Asthma
__ Y __ N Atopic (allergy prone)
__ Y __ N Back problems
__ Y __ N Blood disease
__ Y __ N Cancer
__ Y __ N Chemical dependency
__ Y __ N Chemotherapy
__ Y __ N Circulatory problems
__ Y __ N Cortisone treatments
__ Y __ N Cough, persistent
__ Y __ N Cough up blood
__ Y __ N Diabetes
__ Y __ N Epilepsy
__ Y __ N Fainting
__ Y __ N Food allergies
__ Y __ N Glaucoma
__ Y __ N Headaches
__ Y __ N Heart murmur
__ Y __ N Heart problems
Describe _____________
__ Y __ N Hemophilia/ Abnormal Bleeding
__ Y __ N Herpes
__ Y __ N Hepatitis
__ Y __ N High blood pressure
__ Y __ N Jaw pain
__ Y __ N Kidney disease or malfunction
__ Y __ N Liver Disease
__ Y __ N Material allergies (latex, wool, metal, chemicals)
__ Y __ N Mitral valve prolapse
__ Y __ N Nervous problems
__ Y __ N Pacemaker/Heart Surgery
__ Y __ N Psychiatric Care
__ Y __ N Rapid weight gain or loss
__ Y __ N Radiation treatment
__ Y __ N Respiratory disease
__ Y __ N Rheumatic fever
__ Y __ N Scarlet fever
__ Y __ N Shingles
__ Y __ N Shortness of breath
__ Y __ N Skin Rash
__ Y __ N Spina Bifida
__ Y __ N Stroke
__ Y __ N Surgical implant
__ Y __ N Swelling of feet or ankles
__ Y __ N Thyroid disease of malfunction
__ Y __ N Tobacco habit
__ Y __ N Tonsillitis
__ Y __ N Tuberculosis
__ Y __ N Ulcer/Colitis
__ Y __ N Venereal disease

List medications you are currently taking, if any:
____
____
____

Are you allergic to the following:
__ Penicillin __ Keflex __ Clindamycin __ Other
__ Aspirin __ Vicodin __ Codeine __ Motrin
Other Allergies ________________________

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature ____________________________ Print Name ______________________________ Date ____________

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