DENTAL HISTORY

Reason for visit: _____

Are your teeth painful or sensitive to: (please circle) hot cold sweet chewing

When was the last time your teeth were cleaned by a hygienist? _____

YES NO Do your gums bleed?
YES NO Do you have a history of periodontal disease?
YES NO Have you had regular dental care?
YES NO Do you have any sores or swelling inside your mouth? If yes, describe _____

HEALTH QUESTIONNAIRE

Name of medical doctor: _____Phone Number: _____

Date of last medical examination: _____

Have you been hospitalized in the past 5 years? YES NO If so, give date and reason: _____

Have you ever had any of the following? Please circle yes or no.

YES NO Is there any medical reason you should be on antibiotics for dental appointments?
YES NO Do you have an artificial joint? (knee, hip, etc…)
YES NO Heart Condition: (please circle) heart murmur, rheumatic fever, high blood pressure, low blood pressure, low blood pressure, stroke, heart attack, angina, shortness of breath, severe chest Pains, blood transfusion, mitral valve prolapse.
YES NO (please circle) Hay Fever, asthma, sinus condition, tuberculosis, emphysema
YES NO Diabetes
YES NO Epilepsy, convulsions or fainting
YES NO HIV or AIDS, date tested _____
YES NO Sexually Transmitted Diseases
YES NO Anemia, excessive bleeding or blood diseases
YES NO Hepatitis, type _____
YES NO Arthritis, type _____
YES NO Mental, psychiatric or psychological disorders
YES NO Stomach ulcers
YES NO If female, are you pregnant? Due Date: _____
YES NO Hormone therapy
YES NO Cancer, type _____
YES NO Radiation therapy, chemotherapy, or cancer surgery
YES NO Alcohol or Drug Abuse
YES NO Do you smoke or use tobacco? How often? _____
YES NO Medication Allergies _____
YES NO Are you sensitive to any local or general anesthetics? Type_____
YES NO Any previous dental complications? Describe _____

MEDICAL HISTORY UPDATE (office use only)

_____
_____
_____
_____