

DENTAL HEALTH HISTORY

(Confidential)

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sore or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) Yes No

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give an approximate date _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following

- | | | |
|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever |

Medications

List Medications you are currently taking:

Pharmacy name _____

Phone(____) _____

Allergies

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> Codeine | _____ |
| <input type="checkbox"/> Local Anesthetic | _____ |
| <input type="checkbox"/> Penicillin | _____ |

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____