DENTAL AND MEDICAL HISTORY

DENTAL HISTORY

Reason for todays's visit: _____ Former dentist: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

How would you rate the condition of your mouth? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

I routinely see my dentist every: ❑ 3 MOS ❑ 4 MOS ❑ 6 MOS ❑ 12 MOS ❑ Not routinely

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

PLEASE CIRCLE YES IF YOU HAD ANY OF THE FOLLOWING:

Y / N	Bad Breath	Y / N	Fingernail Biting	Y / N	Orthodontic Treatment
Y / N	Bleeding Gums	Y / N	Food Collection Between The Teeth	Y / N	Pain Around Ear
Y / N	Blisters On Lips Or Mouth	Y / N	Grinding Teeth	Y / N	Periodontal Treatment
Y / N	Coffee, Tea	Y / N	Jaw Pain Or Tiredness	Y / N	Sensitivity To Biting
Y / N	Burning Sensation On Tongue	Y / N	Lip Or Cheek Biting	Y / N	Sensitivity To Cold
Y / N	Do You Smoke?	Y / N	Loose Teeth Or Broken Filling	Y / N	Sensitivity To Heat
Y / N	Clicking Or Popping Jaw	Y / N	Mouth Breathing	Y / N	Sensitivity To Sweets
Y / N	Dry Mouth	Y / N	Mouth Pain, Brushing	Y / N	Swollen Or Tender
Y / N	Sores Or Growths In Your Mouth				

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" ? ❑ YES ❑ NO

These include tiludronate (Skelid), alendronate(Fosamax), risedronate(Actonel), etidronate(Didronel), ibandronate (Bonival), pamidronate (Aredia) and zoledronic acid (Zometa).

Have you ever had any serious illnesses or operations? ❑ NO ❑ YES, Please describe _____

WOMEN: Are you pregnant? ❑ YES ❑ NO Nursing? ❑ YES ❑ NO Taking birth control? ❑ YES ❑ NO

PLEASE CIRCLE YES IF YOU HAD ANY OF THE FOLLOWING:

Y / N	Anemia	Y / N	Diabetes	Y / N	Hepatitis	Y / N	Scarlet Fever
Y / N	Arthritis	Y / N	Cortisone Treatments	Y / N	Hernia Repair	Y / N	Shortness Of Breath
Y / N	Artificial Heart Valves	Y / N	Cough, Persistent	Y / N	High Blood Pressure	Y / N	Skin Rash
Y / N	Artificial Joints, Pins	Y / N	Cough Up Blood	Y / N	HIV/AIDS	Y / N	Spleen Removed
Y / N	Asthma	Y / N	Congenital Heart	Y / N	Jaw Pain	Y / N	Stroke
Y / N	Back Problems	Y / N	Epilepsy	Y / N	Kidney Disease	Y / N	Swelling Feet/Ankles
Y / N	Bleeding Abnormally	Y / N	Fainting Or Dizziness	Y / N	Liver Disease	Y / N	Thyroid Problems
Y / N	Blood Disease	Y / N	Headaches	Y / N	Pacemaker	Y / N	Tobacco Habit
Y / N	Chemical Dependency	Y / N	Heart Murmur	Y / N	Radiation Treatment	Y / N	Tuberculosis
Y / N	Chemotherapy	Y / N	Heart Problems	Y / N	Respiratory Disease	Y / N	Ulcer
Y / N	Circulatory Problems	Y / N	Hemophilia	Y / N	Rheumatic Fever	Y / N	Venereal Disease

List all medications you are taking:

_____

_____

_____

PLEASE CIRCLE IF YOU ARE ALLERGIC TO:

❑ Aspirin ❑ Codeine ❑ Latex ❑ Local Anesthesia

❑ Penicillin ❑ Other _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor of any changes in my medical history or any new medications I may be taking.

X _____ _____

Patient Signature Or Legal Guardian / Representative Signature Date

X _____ _____

Doctor's Signature Date