DENTAL HISTORY

Previous Dentist : ____ Phone #: (___) - ____ - ____

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

Check all that apply

☐ Bad breath	☐ Gag reflex	☐ Loose teeth
☐ Bleeding gums	☐ Broken fillings	☐ Sensitive to biting/chewing
☐ TMJ pain	☐ Sensitive to sweets	☐ Sensitive to hot/cold
☐ Gum disease	☐ Grind/clench teeth	☐ Food packing between teeth
		☐ Bad dental experience in past

Do you smoke or use any tobacco products? ☐ *Yes* ☐ *No* What and how often? __________________________

How often do you brush? ______________________ How often do you floss? ______________________

If you could change anything about your smile, what would it be? ____________________________________

____

Other information about your dental health : ____

____

MEDICAL HISTORY

Physician : ____

Date of last exam : __/__/_____ Currently under doctor's care? ☐ *Yes* ☐ *No*

Why? ____

Are you pregnant? ☐ *Yes* ☐ *No* Due Date : __/__/_____ Do you take birth control? ☐ *Yes* ☐ *No*

Do you have panic attacks? ☐ *Yes* ☐ *No*

Are you allergic to: (check all that apply)

☐ Penicillin ☐ Sulfa Drugs ☐ Codeine ☐ Aspirin ☐ Iodine ☐ Latex

☐ Other : ____

List current medications : ____

____

Have you had prosthetic joint replacement surgery? ____

Do you snore? ☐ *Yes* ☐ *No* Have you been diagnosed with sleep apnea? ☐ *Yes* ☐ *No*

Do you have or have you had any of the following: (Check all that apply)

☐ AIDS/HIV+	☐ Emphysema	☐ Persistent cough	☐ Hepatitis/Jaundice	☐ Shingles
☐ Anaphylaxis	☐ Cough up blood	☐ High blood pressure	☐ Low blood pressure	☐ Anemia
☐ Arthritis	☐ Diabetes	☐ Jaw pain	☐ Shortness of breath	☐ Skin rash
☐ Epilepsy	☐ Kidney disease	☐ Liver disease	☐ Rheumatic fever	☐ Stroke
☐ Food allergy	☐ Blood disease	☐ Metal allergy	☐ Artificial heart valve	☐ Headaches
☐ Heart murmur	☐ Thyroid disease	☐ Back problems	☐ Mitral valve prolapse	☐ Pacemaker
☐ Psychiatric care	☐ Nervous problems	☐ Herpes	☐ Rapid weight loss/gain	☐ Ulcer
☐ Cancer	☐ Heart problems	☐ Respiratory disease	☐ Circulatory problems	☐ Hemophilia
☐ Tonsillitis	☐ Tuberculosis	☐ Drug use	☐ Swelling of feet/ankles	☐ Colitis
☐ Chemotherapy	☐ Radiation therapy			

Other ____

Signature : ______________________ Date: ______/______/______