DENTAL HEALTH HISTORY
(Confidential)

Patient's Name_____ Date: _____

Date of Birth_____ Sex: _____ Height: _____ Weight: _____

Physician's Name _____ Dr. Phone # _____

Does the patient smoke? _____ Does the patient consume more than 3 oz. of alcohol a day_____

Does the Patient have or has this patient ever had any of the following diseases or problems?
CIRCLE if you have or have had any of the following:

Anemia	Arthritis, Rheumatism	Artificial Heart Valves
Artificial Joints	Asthma	Back Problems
Cancer	Chemical Dependency	Circulatory Problems
Cortisone Treatments	Cough, Persistent	Cough up Blood
Diabetes	Epilepsy	Fainting
Glaucoma	Headaches	Heart Murmur
Heart Problems	Hemophilia	Hepatitis ____
High Blood Pressure	Kidney Disease	Liver Disease
Mitral Valve Prolapse	Pacemaker	Radiation Treatment
Respiratory Disease	Rheumatic Fever	Scarlet Fever
Shortness of Breath	Skin Rash	Stroke
Swelling of Feet/Ankle	Thyroid Problems	Tobacco Habit
Tuberculosis	Ulcer	Venereal Disease_____

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

(WOMEN) Are You Pregnant? Y or N Nursing? Y or N Taking birth control? Y or N

MEDICATIONS

List medications you're currently taking: _____

Pharmacy Name _____ Phone # _____

ALLERGIES

Aspirin	Codeine
Local Anesthetic	Penicillin
Sulfa	Latex _____
Other _____	

DENTAL HISTORY

Reason for Today's Visit _____Date of last Dental Care_____
Former Dentist_____ Date of last X-Rays_____

Check if you have had problems with any of the following:

Bad Breath	Bleeding Gums	Clicking or popping jaw
Food collection between teeth	Grinding teeth	Loose teeth or broking fillings
Periodontal Treatment	Sensitivity to cold	Sensitivity to hot
Sensitivity to sweets	Sensitivity when biting	Sores or growths in your mouth

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

CHILDREN AND ADOLESCENTS

Is this your child's first visit in a dental offe? Yes or No
Does you child have a finger sucking habit? _____
Is your child involved in any of the following programs:
Speech Therapy_____ Special Education _____
Physically Handicapped_____

YOUR SIGNATURE:_____