Dental History

Reason for Visit _____ Former Dentist _____

Date of Last Visit _____ Date of Last Xrays _____

Circle any that apply:

Bad Breath **Bleeding Gums** **Clicking/Popping Jaw** **Collection Between Teeth** **Grinding Teeth**

Loose Teeth/Broken Teeth **Past Periodontal Treatment** **Sores in Mouth** **Hot/Cold Sensitivity**

Sweets Sensitivity **Chewing Sensitivity**

Medical History

Physician's Name _____ Last Visit _____

Medications Currently Taken _____

Allergies to Medications, Latex, Metals _____

Serious Illnesses or Operations _____

Any Tranfusions/Exposure to AIDS Virus _____ Pregnant/Nursing _____

Circle All That Apply:

AIDS	Cough, Persistent	Jaundice	Short of Breath
Anesthesia Allergy	Cough Up Blood	Jaw Pain	Sinus Problems
Anemia	Diabetes	Kidney Disease	Skin Rash
Arthritis/Rheumatism	Epilepsy	Liver Disease	Stroke
Artificial Heart Valve	Fainting	Low Blood Pressure	Swelling Feet/Ankles
Artificial Joints	General Allergies	Mitral Valve Prolapse	Thyroid Problems
Asthma	Glaucoma	Nervous Problems	Tobacco Habit
Back Problems	Headaches	Pacemaker	Tonsillitis
Blood Disease	Heart Murmur	Psychiatric Care	Tuberculosis
Cancer	Heart Problems	Radiation Treatment	Venereal Disease
Chemical Dependency	Hemophilia	Recent Weight Loss	
Chemotherapy	Hepatitis	Respiratory Disease	
Circulatory Problems	High Blood Pressure	Rheumatic Fever	
Cortisone Treatments	HIV Positive	Scarlet Fever	NONE OF THE ABOVE

Signature _____ Date _____