New Patient Dental Health History

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Print Patient Name:	**Date of Birth:**
Primary Physician's Name:	**Date of last visit:**
Former Dentist's Name:	**Date of last visit:**

DENTAL PROBLEMS

Please check the box of any that apply:

Bad breath	☐	Fingernail biting	☐	Mouth pain, brushing	☐
Bleeding gums	☐	Food collection between teeth	☐	Orthodontic treatment	☐
Blisters on lips/mouth	☐	Foreign objects	☐	Pain around ear	☐
Bubble or pimple on gum	☐	Grinding teeth	☐	Periodontal treatment	☐
Burning sensation on tongue	☐	Gums swollen or tender	☐	Sensitivity to cold	☐
Chew on one side of mouth	☐	Jaw pain or tiredness	☐	Sensitivity to heat	☐
Cigarette/pipe/cigar smoking	☐	Lip or cheek biting	☐	Sensitivity to sweets	☐
Clicking or popping jaw	☐	Loose teeth or broken fillings	☐	Sensitivity when biting	☐
Dry mouth	☐	Mouth breathing	☐	Sores or growths in mouth	☐

ALLERGIES

Please check the box to indicate if you are allergic to any of the following:

Asprin	☐	Latex	☐	Penicillin	☐
Barbiturates (sleeping pills)	☐	Bleach	☐	Sulfa	☐
Codeine	☐	Local anesthetic	☐	Iodine	☐
Other (please list):					
Food allergies:					

MEDICATIONS

Please list any medications you are currently taking:

WOMEN

Please check the box to indicate if any of the following apply:

Pregnant*	☐	*Due date (if pregnant):		
Nursing	☐	On Birth Control Pills	☐	

Patient Name:	**Date of Birth:**

OTHER MEDICALLY DIAGNOSED PROBLEMS

Please check the box to indicate if you have had problems with or are presently complaining of any of the following:

Abdominal discomfort	☐	Circulatory problems	☐	High blood pressure	☐	Persistent cough	☐
Acid reflux	☐	Congenital heart lesions	☐	Hay fever	☐	Radiation treatment	☐
ADD	☐	Cortisone treatments	☐	Head/Neck radiation	☐	Recent surgery	☐
ADHD	☐	Colitis	☐	Indigestion	☐	Respiratory disease	☐
AIDS/HIV	☐	Cough, persistent or bloody	☐	Jaundice	☐	Rheumatic fever	☐
Alcohol abuse	☐	Cystic Fibrosis	☐	Joint replacement	☐	Scarlet Fever	☐
Anemia	☐	Diabetes	☐	Kidney disease	☐	Shortness of breath	☐
Anxiety	☐	Dental visit related anxiety	☐	Kidney stones	☐	Sinus trouble	☐
Arthritis / Rheumatism	☐	Depression	☐	Liver disease	☐	Skin rash / disorders	☐
Artificial heart valves	☐	Drug abuse	☐	Low blood pressure	☐	Special diet	☐
Artificial joints	☐	Emphysema	☐	Light-headedness	☐	Stroke	☐
Asthma	☐	Epilepsy	☐	Mitral valve prolapsed	☐	Swollen feet / ankles	☐
Autism	☐	Fainting or dizziness	☐	Muscular Dystrophy	☐	Swollen neck glands	☐
Back problems	☐	Glaucoma	☐	Nervous problems	☐	Thyroid problems	☐
Bleeding abnormally	☐	Headaches	☐	Nausea	☐	Tonsillitis	☐
Blood disease	☐	Heart murmur	☐	Osteoporosis	☐	Tuberculosis	☐
Bronchitis	☐	Heart problems	☐	Pacemaker	☐	Tumor or growths	☐
Cancer	☐	Hepatitis*	☐	Psychiatric care	☐	Ulcer	☐
Chemical dependency	☐	If **Yes**, circle type: A B C		Palpitations	☐	Venereal Disease	☐
Chemotherapy	☐	Herpes	☐	Pneumonia	☐	Weight loss or gain	☐

ADDITIONAL INFORMATION

Please check the box if the answer is YES to any of the following. If NO, leave empty

Do you need to pre-medicate for dental procedures?	☐
Are you taking blood thinners?	☐
Have you ever taken bisphosphonates or bone- building drugs?	☐
Do you have any physical limitations? (wheelchair, walker, mobility)	☐
If yes, please describe:	

DENTAL INFORMATION

Please answer the following:

Reason for today's visit:	
How often do you floss?	How often do you brush?

Patient / Guardian Signature:	**Date:**
Provider Signature:	**Date:**
Patient Name:	**Date:**