



## New Patient Dental Health History

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

<b>Print Patient Name:</b>	<b>Date of Birth:</b>
<b>Primary Physician's Name:</b>	<b>Date of last visit:</b>
<b>Former Dentist's Name:</b>	<b>Date of last visit:</b>

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

<b><u>ALLERGIES</u></b>			
Please check the box to indicate if you are allergic to any of the following:			
Asprin		Latex	
Barbiturates (sleeping pills)		Bleach	
Codeine		Local anesthetic	
Other (please list):			
Food allergies:			

<b><u>MEDICATIONS</u></b>
Please list any medications you are currently taking:

<b><u>WOMEN</u></b>			
Please check the box to indicate if any of the following apply:			
Pregnant*		*Due date (if pregnant):	
Nursing		On Birth Control Pills	

<b>Patient Name:</b>	<b>Date of Birth:</b>
----------------------	-----------------------

**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 <b>Yes</b> , circle type: <b>A B C</b>	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?



<b>Patient / Guardian Signature:</b>	<b>Date:</b>
<b>Provider Signature:</b>	<b>Date:</b>
<b>Patient Name:</b>	<b>Date:</b>