



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:
Preferred Name:	Prior Last Name:
Primary Physician's Name:	Date of last visit:
Former Dentist's Name:	Date of last visit:

<u>DENTAL PROBLEMS</u>			
Please check the box of any that apply:			
<input type="checkbox"/> None	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Bleeding gums	
<input type="checkbox"/> Blisters on lips/mouth	<input type="checkbox"/> Bubble or pimple on gum	<input type="checkbox"/> Burning sensation on tongue	
<input type="checkbox"/> Chew on one side of mouth	<input type="checkbox"/> Cigarette/pipe/cigar smoking	<input type="checkbox"/> Vape	
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Fingernail biting	
<input type="checkbox"/> Food collection between teeth	<input type="checkbox"/> Foreign objects	<input type="checkbox"/> Grinding teeth	
<input type="checkbox"/> Gums swollen or tender	<input type="checkbox"/> Jaw pain or tiredness	<input type="checkbox"/> Lip or cheek biting	
<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Mouth breathing	<input type="checkbox"/> Mouth pain, brushing	
<input type="checkbox"/> Orthodontic treatment	<input type="checkbox"/> Pain around ear	<input type="checkbox"/> Periodontal treatment	
<input type="checkbox"/> Tooth sensitivity to cold	<input type="checkbox"/> Tooth sensitivity to heat	<input type="checkbox"/> Tooth sensitivity to sweets	
<input type="checkbox"/> Tooth sensitivity when biting	<input type="checkbox"/> Sores or growths in mouth		

<u>ALLERGIES</u>			
Please check the box to indicate if you are allergic to any of the following:			
<input type="checkbox"/> None	<input type="checkbox"/> Asprin	<input type="checkbox"/> Barbiturates (sleeping pills)	
<input type="checkbox"/> Codeine	<input type="checkbox"/> Latex	<input type="checkbox"/> Bleach	
<input type="checkbox"/> Local anesthetic	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	
<input type="checkbox"/> Iodine			
<input type="checkbox"/> Other (please list):			
<input type="checkbox"/> Food allergies (please list):			

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

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

Patient Name:	Date of Birth:
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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:

None	ADD	ADHD	AIDS/HIV
Anemia	Anxiety	Arthritis / Rheumatism	Artificial heart valves
Artificial joints	Asthma	Autism	Alcohol abuse
Bleeding abnormally	Blood disease	Bronchitis	Back problems
Cancer	Chemotherapy	Circulatory problems	Congenital heart lesions
Cortisone treatments	Colitis	Cough, persistent or bloody	Cystic Fibrosis
Diabetes	Dental visit related anxiety	Depression	Drug abuse
Emphysema	Epilepsy	Fainting or dizziness	Glaucoma
Headaches	Hepatitis*	Herpes	High blood pressure
Hay fever	If Yes , circle type: A B C	Head/Neck radiation	Heart problems
Indigestion	Jaundice	Joint replacement	Kidney disease
Kidney stones	Liver disease	Low blood pressure	Light-headedness
Mitral valve prolapsed	Muscular Dystrophy	Nervous problems	Nausea
Osteoporosis	Pacemaker	Psychiatric care	Palpitations
Pneumonia	Persistent cough	Radiation treatment	Recent surgery
Respiratory disease	Rheumatic fever	Scarlet Fever	Shortness of breath
Sinus trouble	Skin rash / disorders	Special diet	Stroke
Swollen feet / ankles	Swollen neck glands	Thyroid problems	Tonsillitis
Tuberculosis	Tumor or growths	Ulcer	Venereal Disease
Weight loss or gain	Other:		

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?	<input type="checkbox"/>
Are you taking blood thinners?	<input type="checkbox"/>
Have you ever taken bisphosphonates or bone-building drugs?	<input type="checkbox"/>
Do you have any physical limitations? (wheelchair, walker, mobility)	<input type="checkbox"/>
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: