Dental/Medical History

Chief Complaint (reason for your visit today): _____

Past or Present History of (circle all that apply):

Dental

Bad Breath	Bleeding Gums	Blisters on lips or mouth	Burning sensation on tongue
Chew on one side of mouth	Cigarette, Pipe or Cigar Smoking	Clicking or Popping Jaw	Dry Mouth
Fingernail biting	Food Collection between the teeth	Foreign objects	Grinding teeth
Gums swollen or tender	Jaw pain or tiredness	Lip or cheek biting	Loose teeth or broken fillings
Mouth breathing	Mouth pain	Orthodontic treatment	Pain around ear
Previous Periodontal treatment	Sensitivity to cold	Sensitivity to heat	Sensitivity to sweets
Sensitivity when biting	Sores or growth in your mouth		

Medical

AIDS/HIV	Anemia	Artificial Joints	Asthma
Back Problems	Bleeding Abnormally	Arthritis, Rheumatism	Artificial Heart Valves
Blood Disease	Cancer	Cough, persistent or bloody	Cortisone Treatments
Circulatory Problems	Congenital Heart Problems	Chemical Dependency	Chemotherapy
Epilepsy	Fainting or Dizziness	Diabetes	Emphysema
Venereal Disease	Weight Loss	Glaucoma	Headaches
Heart Murmur	Heart Problems	Herpes	High Blood Pressure
Hepatitis	Jaundice	Jaw Pain	Low Blood Pressure
Kidney Disease	Liver Disease	Pacemaker	Psychiatric Care
Mitral Valve Prolapse	Nervous Problems	Radiation Treatment	Respiratory Disease
Rheumatic Fever	Scarlet Fever	Skin rash	Special Diet
Shortness of breath	Sinus trouble	Swollen Neck Glands	Thyroid Problems
Stroke	Swollen Feet or Ankles	Tumor or growth on head or neck	Ulcer
Tonsillitis	Tuberculosis		

How often do you brush _____, Floss_____?
Are you in pain at this time?; If so explain _____
Is your pain due to an accidental injury or accident? YES or NO
Are there any other health conditions you have that are not listed? Yes or No
If so, please explain:

Please list all allergies: _____
Please list all medications you are taking: _____

_____

Women Only:
Are you pregnant? Yes No, Due Date: _____ Nursing? Yes No
Had an exposure to HPV? Yes No

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential. I am aware that a copy of my insurance identification card will be made available and a copy kept in my records. I am responsible for updating this information if and when there are changes.

Signature: _____ Date: _____