Dental & Medical History

Do you have any present dental complaints or concerns?

☐ Yes ☐ No

If yes, please explain:

_____

Do your gums bleed?

☐ Yes ☐ No

How many times a day do you brush your teeth?

_____

What type of toothbrush do you use?

Manual Toothbrush Electric Toothbrush

Do you floss?

☐ Yes ☐ No

Do you use mouth rinse?

☐ Yes ☐ No

Do you ever have popping or discomfort in the jaw joint?

☐ Yes ☐ No

Do you or have you been told you clench or grind your teeth?

☐ Yes ☐ No

What is the name of your previous dentist?

_____

Date of last x-rays? (taken at another office)

_____

What is the name of your current primary care physician or internal medicine doctor?

_____

What is the dale of your last medical exam?

_____

Have you been hospitalized or had surgery in the past 2 years?

Dental & Medical History

☐ Yes ☐ No

If yes, please list date(s) and reason for hospitalization or type of surgery?

_____

Do you smoke or chew tobacco?

☐ Yes ☐ No

Do you drink alcohol?

☐ Yes ☐ No

Do you use recreational drugs?

☐ Yes ☐ No

Please list all food or drug related allergies.

_____

_____

Please list all current doctor prescribed medicine, over the counter medicine and vitamins or supplements you take on a regular basis (Please bring a list of all current medicine to your appointment.)

Do you now have or have you had any of the following medical conditions?

PLEASE MARK ANY AND ALL THAT APPLY TO YOU

- ☐ Artificial Joints
- ☐ Excessive Bleeding
- ☐ Kidney Disease
- ☐ Ulcers
- ☐ Dizziness
- ☐ Heart Murmur
- ☐ Mental Disorders
- ☐ Stomach Problems
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Liver Disease
- ☐ Rheumatism
- ☐ Blood Disease
- ☐ Heart Disease
- ☐ Respiratory Problems
- ☐ Anemia
- ☐ Fainting
- ☐ HIV

Dental & Medical History

- ☐ Pacemaker
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Head Injuries
- ☐ Nervous Disorders
- ☐ Stroke
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Sinus Problems
- ☐ Cancer
- ☐ Hay Fever
- ☐ Latex Allergy
- ☐ Rheumatic Fever
- ☐ Venereal Disease
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Radiation Treatment
- ☐ Tumors

Remarks of Concerns regarding your medical history:

_____

Do you wish to talk to doctor privately about anything special?

Response Date: