Dental History

What would you like us to do for you today?__________________ Are you in dental discomfort? __________

Former dentist ___________________________ address ______________________________

Telephone number ____________________ Date of last visit __________ x-rays ___________

Circle all that apply:

Bad breath	Food collection between teeth	Periodontal treatment	Sensitivity to sweets
Bleeding Gums	Grinding or clenching	Sensitivity to cold	Sensitivity when biting
Clicking or popping jaw	Loose teeth or broken fillings	Sensitivity to hot	Sores in mouth

How often do you brush ? ____

Electric toothbrush ______________________ manual toothbrush _____________________

Mouthwash_____________________________ Floss _______________________________

Have you ever experienced an adverse reaction during or in conjunction with medical or dental procedure? If yes Please explain ____

Medical History

Have you ever had a blood transfusion? _________________ When _________________

Have you ever taken Fen – Phen / Redux_________________ When ________________

Circle all that apply :

Aids/ Hiv Positive	Cough, persistent	Jaw pain	Shingles
Anaphylaxis	Cough up blood	Kidney disease	Shortness of breath
Anemia	Diabetes	Liver disease	Skin rash
Arthritis, Rheumatism	Epilepsy	Material allergies	Heart Surgery
Artificial heart valves	Fainting	Latex allergies	Stroke
Artificial joints	Food allergies	Mitral valve prolapse	Surgical implant
Asthma	Glaucoma	High blood pressure	Swelling of feet
Atopic (allergy prone)	Headaches	Pacemaker	Thyroid disease
Back problems	Heart murmur	Psychiatric care	Abnormal bleeding
Cancer	Heart problems	Rapid weight gain or loss	Tobacco habit
Chemical dependency	Describe:__________	Radiation treatment	Tonsillitis
Chemotherapy	Hemophilia	Respiratory disease	Tuberculosis
Circulatory problems	Herpes	Rheumatic fever	Ulcer / Colitis
Cortisone treatments	Hepatitis	Scarlet fever	Venereal disease

Are you pregnant ? _________Nursing ? _______________Birth control pills ? _______