Advanced Family Dentistry

PATIENT NAME:

DENTAL HISTORY

Reason for today's visit ________________

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Former Dentist ________________

City/State ________________

Date of last dental visit ________________

Date of last dental X-rays ________________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No
Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, cigar smoking or chew tobacco	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in you mouth	☐ Yes	☐ No

How often do you floss? ________________

How often do you brush? ________________

MEDICAL HISTORY UPDATE

Medical Doctor Name: ________________ Date of Last Visit ________________

Have you had any serious illnesses or operations? ________________ If yes, describe ________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control pills? ☐ Yes ☐ No

Check (✓) If you have or have had any of the following:

Y	N	**Conditions**
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Cholesterol Problems
☐	☐	Congenital Heart Defect
☐	☐	Cortisone Treatments
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Eating Disorder
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV+/AIDS
☐	☐	Heart Murmur
☐	☐	Heart Problems/Surgeries
☐	☐	Hemophilia
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Jaundice
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis
☐	☐	Pacemaker
☐	☐	Pain In Jaw Joints
☐	☐	Psychiatric Care
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Sudden Weight Change
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Tumor
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	

Y	N	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry or Metals
☐	☐	Latex
☐	☐	Sulfa
☐	☐	Penicillin
☐	☐	Tetracycline

Other ________________

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MEDICATIONS

List medications and herbal or dietary supplements you are currently taking and for what condition: ________________

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Pharmacy Name ________________

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have in the completion of this form.

Date ________________ Patient Signature ________________

Date ________________ Doctor Signature ________________