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**DENTAL HISTORY**

Your current dental health is:      Excellent                              Good                              Fair                              Poor

Are you apprehensive about dental treatment? If so, what are your concerns? \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_ Date of last visit \_\_\_\_\_

Describe any dental problems or concerns \_\_\_\_\_

- |     |    |   |
|-----|----|---|
| Yes | No | Have you ever had periodontal treatment?                    |
| Yes | No | Have you ever had root planing (deep cleaning) done?        |
| Yes | No | Are your gums red, swollen, glossy or tender?               |
| Yes | No | Do your gums bleed or hurt?                                 |
| Yes | No | Do you have a bite plate or mouth guard?                    |
| Yes | No | Do you have clicking, popping or pain in your jaw?          |
| Yes | No | Do you clench or grind your teeth?                          |
| Yes | No | Do you experience headaches, neck aches or shoulder aches?  |
| Yes | No | Do you suffer from migraine headaches?                      |
| Yes | No | Do you have difficulty opening or closing your mouth?       |
| Yes | No | Have you experienced a serious injury to the mouth or head? |

**HEALTH HISTORY**

Check if you have or have had any of the following:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Pacemaker                     | <input type="checkbox"/> Stroke                             | <input type="checkbox"/> Allergic or other reaction to |
| <input type="checkbox"/> Heart murmur                  | <input type="checkbox"/> Tumor or growth                    | <input type="checkbox"/> local anesthetics             |
| <input type="checkbox"/> Mitral valve prolapse         | <input type="checkbox"/> Kidney trouble or dialysis         | <input type="checkbox"/> aspirin                       |
| <input type="checkbox"/> Rheumatic heart disease/fever | <input type="checkbox"/> Persistent swelling in neck        | <input type="checkbox"/> penicillin or other           |
| antibiotics  |   |  |
| <input type="checkbox"/> Damaged heart valve           | <input type="checkbox"/> Sexually transmitted disease       | <input type="checkbox"/> sulfa drugs                   |
| <input type="checkbox"/> Heart trouble                 | <input type="checkbox"/> Epilepsy                           | <input type="checkbox"/> sedatives                     |
| <input type="checkbox"/> Heart attack                  | <input type="checkbox"/> Cancer                             | <input type="checkbox"/> codeine                       |
| <input type="checkbox"/> Angina                        | <input type="checkbox"/> Problems with immune system        | <input type="checkbox"/> other                         |
| <input type="checkbox"/> High blood pressure           | <input type="checkbox"/> Abnormal bleeding                  | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Arteriosclerosis              | <input type="checkbox"/> Blood disorders                    | <input type="checkbox"/> Nursing                       |
| <input type="checkbox"/> Congenital heart defect       | <input type="checkbox"/> Artificial heart valve             | <input type="checkbox"/> Tobacco/alcohol use           |
| <input type="checkbox"/> Allergies                     | <input type="checkbox"/> Pregnant                           | <input type="checkbox"/> Thyroid problems              |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> AIDS or HIV                        | <input type="checkbox"/> Respiratory problems          |
| <input type="checkbox"/> Artificial joint replacement  | <input type="checkbox"/> Hepatitis, jaundice, liver disease |  |

Please list all medications you are taking \_\_\_\_\_

To the best of my knowledge, the above information is current and accurate. I understand that it is my responsibility to inform the doctor of any changes in my health.

\_\_\_\_\_  
Signature of patient, parent or Personal Representative

\_\_\_\_\_  
Date