**Dental History**

Last Dental Exam: _____ Last Cleaning: _____

How often do you floss? _____ How often do you brush? _____

Are you having pain? If so, for how long? _____

**Do you currently or have you ever had:**

| | | |
|---|---|---|
| ____bad breath | ____blisters on mouth or lips | ____burning sensation on tongue |
| ____dry mouth | ____chew ice | ____clench or grind teeth |
| ____tobacco use | ____food stuck between teeth | ____sore spots |
| ____swollen gums | ____sensitivity to hot or cold | ____bleeding gums |
| ____jaw pain/headaches | ____loose teeth | ____broken fillings |
| ____root canal | ____periodontal treatment | ____ringing in ears |
| ____crown or bridge | ____denture | ____difficulty with previous dental work |

**Medical History**

Physicians Name/Phone: _____ Are you in good health? Y/N.

Are you under a physician's treatment now? If yes, what condition is being treated?

_____

Last physical exam: _____ Have you ever been hospitalized or had a major operation?

If Yes, explain_____

Are you being treated for osteoporosis? _____ Do you have an artificial heart valve? _____

Have you had a joint replacement? If yes, when?_____Do you require pre-medication? _____

Please list all medications_____

(if you have a list, we'll gladly copy it for you)

**Are you allergic to any of the following**? _____Aspirin _____Penicillin _____Codeine _____Tetracycline _____ Erythromycin _____Latex, _____ Other_____please explain _____

**Have you ever had any of the following?**

| | | |
|---|---|---|
| ____AIDS/HIV positive | ____cortisone meds | ____herpes |
| ____anaphylaxis | ____diabetes | ____kidney problems |
| ____asthma | ____ congenital heart disorder | ____leukemia |
| ____breathing problems/COPD | ____drug addiction | ____liver disease |
| ____Alzheimer's disease | ____epilepsy | ____low/high blood pressure |
| ____anemia | ____excessive bleeding | ____mitral valve prolapse |
| ___artificial joint | ____fainting spells | ____pace maker |
| ____artificial heart valve | ____glaucoma | ____parathyroid disease |
| ____blood disease | ____heart disease | ____radiation treatment |
| ____cancer | ____heart surgery | ____rheumatic fever |
| ____chemotherapy | ____heart murmur | ____sinus trouble |
| ____chest pains | ____hepatitis A | ____stroke |
| ____convulsions | ____hepatitis B or C | |

Have you ever had a serious illness or condition not listed here? If so, please explain: _____

_____

**Women**

Are you pregnant? If so, expected delivery date? _____ Nursing? _____