DENTAL HISTORY

NAME ____

YES	NO	
☐	☐	Do you presently have pain in your mouth?
☐	☐	Do you clench or grind your teeth?
☐	☐	Do any teeth feel loose?
☐	☐	Do you have any food traps?
☐	☐	Do your gums bleed when you brush?
☐	☐	Have your gums ever been treated?
☐	☐	Have you ever injured your face or jaw?
☐	☐	Are you allergic to latex?

Are any of your teeth sensitive to?

☐ Heat ☐ Cold ☐ Biting Pressure ☐ Sweets

When was your last dental appointment? __________________

For what purpose? ____

MEDICAL HISTORY

YES	NO	
☐	☐	Any general health problems? ____
☐	☐	Are you currently under a physician's care? _______________________________________
☐	☐	Have you been hospitalized within the past two years? _____________________________
☐	☐	Are you currently taking any drugs or medications? ________________________________
		***please note the use of recreational drugs can interact adversely with our use of Xylocaine (novocaine)**
☐	☐	Are you allergic to any drugs or medications? ____________________________________
☐	☐	In the past two years, have you extensively travelled or lived outside the U.S.? ____
☐	☐	Do you use tobacco products? ____
☐	☐	Are you pregnant or is there a possibility that you may be pregnant? _________________

Continued on back page…

To the best of your knowledge are you, or have you ever been afflicted with:

- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Respiratory disease
- ☐ Blood disorders
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Night sweats
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Heart attack/ angina
- ☐ Epilepsy
- ☐ Kidney disease
- ☐ Acquired Immunodeficiency Disease
- ☐ Mouth ulcers
- ☐ Tumors or Cancer
- ☐ Yellow jaundice
- ☐ Unusual weight loss
- ☐ Gonorrhea or other venereal disease
- ☐ Low grade fevers
- ☐ Stomach ulcers

Physician ____ Phone _________________________

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT AND VALID.

Signature _______________________________________ Date ___________________________