Patient Name____ Date______________________

DENTAL HISTORY

Dentist ____ Office Phone_____________________

Date of Last Dental Exam_________________

1. Do you feel pain in any of your teeth? Y N
2. Have you had any head, neck, jaw, or mouth injuries? Y N
3. Do you clench or grind your teeth? Y N
4. Do you bite your lips or cheeks frequently? Y N
5. Do you have frequent headaches? Y N
6. Do your gums bleed while brushing or flossing? Y N
7. Are your teeth sensitive to hot, cold, sweet, or sour liquids/foods? Y N

MEDICAL HISTORY

Physician_______________________________________ Office Phone_____________________

Date of Last Medical Exam________________

1. Are you under medical treatment now? Y N
2. Have you ever been hospitalized (surgery or illness)? Y N
3. Are you taking any medications (including non-prescription)? Y N
4. Do you use tobacco? Y N
5. Do you use alcohol, cocaine, or other drugs? Y N
6. Do you have or have you had any of the following?

___High Blood Pressure	___Asthma	___Fainting/Seizures
___Low Blood Pressure	___Hay Fever/Allergies	___Diabetes
___Heart Murmur	___Emphysema	___Hemophilia
___Mitral Valve Prolapse	___Respiratory Problems	___Hepatitis/Jaundice
___Joint Replacement	___Radiation Therapy	___Rheumatic Fever
___Heart Disease	___Cancer	___Stomach Troubles/Ulcers
___Implant	___AIDS/HIV	___Sexually Transmitted Disease
___Stroke	___Other____	

7. Are you allergic to or have you had any reaction to the following?

___Penicillin or other antibiotics	___Sulfa Drugs
___Barbiturates	___Aspirin
___Sedatives	___Pain Medications
___Local anesthetic (e.g. Novocaine)	___Other______________________________

8. WOMEN ONLY:
   - Are you pregnant or think you may be pregnant? Y N
   - Are you nursing? Y N
   - Are you taking birth control pills? Y N