Your current health: ☐ GOOD ☐ FAIR ☐ POOR
Current Physician: _____
Physician phone #: _____
Please list any prescription medications (and for what purpose) that you are currently taking:

_____
_____
_____
_____
_____

Previous Dentist: _____
City/State: _____
Last Dental Visit: _____

Current Dental health: ☐ GOOD ☐ FAIR ☐ POOR
Are you happy with your smile? ☐ YES NO
If no, please tell us why:

_____
_____

Women:
Are you pregnant? ☐ YES ☐ NO Due date: _____
Are you nursing? ☐ YES ☐ NO

Circle if you have or have had been treated for any of the following disease of conditions.

Abnormal Bleeding	Hemophilia
Alcohol/Drug Abuse	Hepatitis A, B, or C
Anemia	High Blood Pressure
Artificial joints/bones/valves	HIV/AIDS
Asthma	Kidney Problems
Cancer	Liver Disease
Congenital Heart Defect	Low Blood Pressure
Diabetes Type 1 Type 2	Migraines
Difficulty Breathing	Mitral Valve Prolapse
Emphysema	Pacemaker
Epilepsy	Psychiatric Problems
Fainting spells	Radiation Problem
Frequent Headaches	Rheumatic Fever
Glaucoma	Scarlet Fever
Glum Disease	Seizures
Heart Attack	Stroke
Heart Murmur	Thyroid Problems
Heart Surgery	Tuberculosis(TB)

Do you have any medical condition that we should be aware of?

_____

Do you smoke or chew tobacco? ☐ YES ☐ NO
Do you need to be pre – medicated for Mitral Valve Prolapse, Heart Murmur, or any kind of joint bone/valve replacement? ☐ YES ☐ NO
If you had joint replacement surgery, what kind and how long ago?

_____

Would you like your teeth to be whiter?	**Y N**		
Would you like for you teeth to be straighter?	**Y N**		
If you had orthodontics, how long ago?	___		
Do you clench or grind your teeth?	**Y N**		
Do you have pain in your jaw, face, or teeth?	**Y N**		
Do you have a bad odor/taste in your mouth?	**Y N**		
Do your gums bleed when brushing or flossing?	**Y N**		
Are your teeth sensitive to cold?	**Y N**		
Does food catch between your teeth?	**Y N**		
Does your spouse complain about you snoring?	**Y N**		
Have you ever done a sleep study?	**Y N**		
Do you use a C-PAP when you sleep?	**Y N**		

Do you have silver or discolored fillings or unnatural looking crowns or bridges that you wish looked different? ☐ **Y** ☐ **N**
If yes, please explain:

_____
_____

Please tell us about any other dental concerns that you may have or any information that you feed is important for us to know:

_____
_____
_____

Please tell us what you are looking for in a dental office, what is the most important to you?

_____
_____
_____

Please circle any of the following which you are allergic to:

Aspirin	Codeine	Dental Aesthetics	Erythromycin
Iodine	Latex	Penicillin	Sulfa

Please list any other allergies:

_____
_____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I understand that it is my responsibility to notify the doctor of any change in my health or medication. Should further information be needed, you have my permission to ask the respective health care provider or agency, who my release such information to you.

Parent/Guardian Signature: _____ Date: _____

History Review
Date: _____