- Dental History -

Previous dentist _____ Last date of checkup or cleaning_____
Do you require antibiotics before dental treatment? Yes _____ No_____
Do you have discomfort in your jaw joint? (TMJ / TMD) Yes _____ No _____
Do your gums ever bleed? Yes_____ No _____
Why have you come to the dentist today? _____
Are you happy with your smile? _____
What would you like to change about your smile?_____
Please circle the most important feature(s) in your smile that you would like to change.
Color Shape Alignment Length Gaps Gum display Other_____

Have you ever had any of the following diseases or medical problems?

Yes **No** – Abnormal Bleeding
Yes **No** – Alcohol / Drug abuse
Yes **No** – Anemia
Yes **No** – Arthritis
Yes **No** – Artificial Bones Joints or valves
Yes **No** – Asthma
Yes **No** – Blood transfusion
Yes **No** – Cancer / Chemotherapy
Yes **No** – Colitis
Yes **No**- Congenital Heart Defect
Yes **No** – Diabetes
Yes **No** – Difficulty breathing
Yes **No** – Emphysema
Yes **No** – Epilepsy
Yes **No** – Fainting spells
Yes **No** – Frequent headaches
Yes **No** – Glaucoma
Yes **No** – Hay Fever
Yes **No** – Heart Murmur
Yes **No** – Heart Attack
Yes **No** – Heart Surgery
Yes **No** - Hemophilia
Yes **No** – Hepatitis A, B, C
Yes **No** – Herpes / Fever blisters
Yes **No** – High Blood pressure
Yes **No** – HIV+ / AIDS
Yes **No** – Kidney problems
Yes **No** – Liver disease
Yes **No** – Low blood pressure
Yes **No** – Mitral valve prolapse
Yes **No** – Pacemaker
Yes **No** – Psychiatric problems
Yes **No** – Radiation treatment
Yes **No** – Rheumatic / Scarlet fever
Yes **No** - Seizures
Yes **No** - Shingles
Yes **No** – Sickle cell disease / traits
Yes **No** – Sinus problems
Yes **No** - Stroke
Yes **No** – Thyroid problem
Yes **No** – Tuberculosis (TB)
Yes **No** - Ulcers
Yes **No** – Venereal disease

Have you been hospitalized for any reason? _____
Please list any other serious medical conditions that you have ever had.

_____

Are you allergic to any of the following?

Yes No – Aspirin
Yes No – Codeine
Yes No – Dental anesthetics
Yes No – Erythromycin
Yes No – Jewelry
Yes No – Latex
Yes No - Metals
Yes No - Penicillin
Yes No –Tetracycline

Please list any other drugs/ materials that you might be allergic to.

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsible to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Print name Date