The Main Street Dentists

DENTAL HEALTH HISTORY

Patient Name_____ **(please print)**

DENTAL HISTORY

Check if you have or had any of the following:

- □ Bad breath
- □ Bleeding gums
- □ Clicking or popping jaw
- □ Dry mouth
- □ Food collection between teeth
- □ Grinding teeth
- □ Loose teeth or broken fillings
- □ Periodontal treatment
- □ Sensitivity to cold
- □ Sensitivity to hot
- □ Sensitivity to sweets
- □ Sensitivity when biting
- □ Sores or growths in your mouth

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit_____

Have you had any serious illnesses or operations?_____ If yes, describe_____

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Birth Control Pills □ Yes □ No

Check (√) if you have had any of the following:

- □ Abnormal Bleeding
- □ AIDS/HIV/Venereal Disease
- □ Allergy-Barbituates (Sleeping Pills)
- □ Allergy - Aspirin
- □ Allergy-Food
- □ Allergy - Latex
- □ Allergy - Narcotic
- □ Allergy - Penicillin
- □ Allergy - Seasonal
- □ Allergy -Sedatives_____
- □ Allergy -Sulfa
- □ Allergy - Other_____
- □ Anemia
- □ Angina
- □ Arteriosclerosis
- □ Arthritis
- □ Artificial Joint
- □ Asthma
- □ Autoimmune Disease
- □ Blood Thinner
- □ Bronchitis
- □ Cancer/Chemotherapy
- □ Chronic Pain
- □ Congested Heart Failure
- □ Damaged Heart Valves
- □ Diabetes
- □ DIzziness
- □ Emphysema
- □ Epilepsy
- □ Fainting or Seizures
- □ Glaucoma
- □ Heart Attack
- □ Heart Condition Other _____
- □ Heart Disease
- □ Hepatitis/Jaundice
- □ Hemophilia
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Mental Disorders
- □ Mitral Valve Prolaps
- □ Nervous Disorders
- □ Neurological Disorder
- □ Osteoporosis
- □ Other _____
- □ Pacemaker
- □ Pt must PREMED
- □ Radiation Treatment
- □ Rheumatic Fever
- □ Rheumatism
- □ Sinus Problems
- □ Stroke
- □ Systemic Lupis Erythematosus
- □ Thyroid Problems
- □ Tuberculosis
- □ Ulcers

MEDICATIONS (Attach a separate list if needed)

_____

_____

Pharmacy Name_____Phone #_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____Date:_____ *Rev 03/22*