The Main Street Dentists, Inc.

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:

☐ Acid Reflux
☐ Anemia
☐ Artificial Heart Valves
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ HIV/AIDS
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Shortness of Breath
☐ Skin Rash
☐ Stroke
☐ Swelling of Feet or Ankles
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tuberculosis

MEDICATIONS

List Medications you are currently taking:

____

____

____

____

Pharmacy Name_____________________________Phone #_______________

ALLERGIES (mark what applies)

☐ Aspirin
☐ Latex
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Penicillin
☐ Jewelry
☐ Sulfa
☐ Local Anesthetic
☐ Other______________________

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 11/17