INTEGRATED DENTAL ARTS

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DENTAL HISTORY

Reason for Today's visit: _____

Date of last dental care: _____ Date of last dental X-rays_____

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

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Have periodontal disease
- ☐ You clench/grind your teeth
- ☐ Like to have whiter teeth
- ☐ Loose teeth
- ☐ Periodontal treatment
- ☐ Sensitivity to (circle one): Cold Hot Sweets When biting
- ☐ You smoke or use tobacco
- ☐ You like your smile
- ☐ You have 1 or more missing teeth that you would like replaced
- ☐ Sores or growths in your mouth
- ☐ Have you been diagnosed or think you might suffer from sleep apnea?
- ☐ You have a CPAP Do you use it?_____
- ☐ You snore when sleeping
- ☐ You wear a night guard when sleeping

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____

Have you ever had any serious illness or operations? _____ If yes, please describe: _____

Have you ever had any blood transfusion? ☐ Yes ☐ No If yes, give approximate date(s):_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Have you or are you taking Bisphosphonates? ☐ Yes ☐ No

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

- ☐ AIDS/HIV+
- ☐ Acid Reflux/GERD
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatment
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems: Describe: _____
- ☐ Hemophilia
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ Herpes/Fever Blisters
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATION

List the medication you are currently taking:

_____

_____

_____

Pharmacy Name: _____

Phone: _____

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other _____

SIGNATURE

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

Signature: _____ **Date:** _____