

**Dental History**

Patient Name: \_\_\_\_\_

Please answer the following:

Chief Complaint? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Do you have swelling? \_\_\_\_\_

**DESCRIPTION OF DENTAL PAIN (Check all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Constant pain               | <input type="checkbox"/> Cold foods/liquids cause pain                  |
| <input type="checkbox"/> Pain comes and goes         | <input type="checkbox"/> Hot foods/liquids cause pain                   |
| <input type="checkbox"/> Dull ache                   | <input type="checkbox"/> Sweets cause pain                              |
| <input type="checkbox"/> Pulsing/throbbing pain      | <input type="checkbox"/> Cold relieves pain                             |
| <input type="checkbox"/> Sharp piercing pain         | <input type="checkbox"/> Gums are sore                                  |
| <input type="checkbox"/> Tooth is sore to touch/bite | <input type="checkbox"/> Tooth is loose, too long, or out of its socket |
| <input type="checkbox"/> Awakens you at night        | <input type="checkbox"/> Change of altitude causes pain                 |
| <input type="checkbox"/> Ear pain                    | <input type="checkbox"/> Gum Boil                                       |

**Medical History**

- |   |     |    |
|---|-----|----|
| Are you in good health? . . . . .   | yes | no |
| Any changes in your health since last year? . . . . .                     | yes | no |
| Have you had any major or minor surgery in the past five years? . . . . . | yes | no |
| Have you had any abnormal bleeding? . . . . .                             | yes | no |
| Do you or have you used controlled substances? . . . . .                  | yes | no |
| Are you now being treated by a physician? . . . . .                       | yes | no |

If so, for what condition? \_\_\_\_\_

Are you taking any medicine(s)? (Include vitamins, daily aspirin and herbs) . . . . . yes no

If so, please list: \_\_\_\_\_

**Are you allergic to or have you had reactions to any of the following:**

- |  |     |    |
|--|-----|----|
| Local anesthetics such as novocaine? . . . . .       | yes | no |
| Penicillin or other antibiotics? . . . . .           | yes | no |
| Sulfa drugs? . . . . .                               | yes | no |
| Barbiturates, sedatives or sleeping pills? . . . . . | yes | no |
| Aspirin . . . . .                                    | yes | no |
| Iodine . . . . .                                     | yes | no |
| Any metals (e.g., nickel, mercury, etc.) . . . . .   | yes | no |
| Latex/rubber . . . . .                               | yes | no |
| Other (please list) _____                            |     |    |

**Medical History (continued)**

**Do you HAVE or have you had (within the last five years) any of the following?**

- |  |  |
|--|--|
| <input type="checkbox"/> Heart murmur<br>with valvular regurgitation? Yes No | <input type="checkbox"/> Hepatitis (circle type) A B C |
| <input type="checkbox"/> Heart attack  | <input type="checkbox"/> Tuberculosis (TB)             |
| <input type="checkbox"/> Heart surgery                                       | <input type="checkbox"/> Asthma                        |
| <input type="checkbox"/> Mitral valve prolapse                               | <input type="checkbox"/> Lung Disease                  |
| <input type="checkbox"/> Heart valve prosthesis                              | <input type="checkbox"/> Sinus condition               |
| <input type="checkbox"/> Angina  | <input type="checkbox"/> TMJ problems                  |
| <input type="checkbox"/> Pacemaker   | <input type="checkbox"/> Psychiatric treatment         |
| <input type="checkbox"/> Rheumatic heart disease or rheumatic fever          | <input type="checkbox"/> Epilepsy                      |
| <input type="checkbox"/> Scarlet fever                                       | <input type="checkbox"/> Diabetes                      |
| <input type="checkbox"/> High blood pressure                                 | <input type="checkbox"/> Ulcer                         |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Kidney disease                |
| <input type="checkbox"/> Hemophilia/Abnormal bleeding                        | <input type="checkbox"/> Thyroid problems              |
| <input type="checkbox"/> Joint replacement                                   | <input type="checkbox"/> AIDS or HIV infection         |
| <input type="checkbox"/> Stroke  | <input type="checkbox"/> Immune disorder               |
| <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> Cancer                        |
| <input type="checkbox"/> Chemical/Alcohol dependency                         | <input type="checkbox"/> Radiation or Chemotherapy     |
|  | <input type="checkbox"/> Any other serious illness     |

**WOMEN ONLY:**

- |  |     |    |
|--|-----|----|
| Are you pregnant or think you may be pregnant? ..... | yes | no |
| Are you nursing? .....                               | yes | no |
| Are you taking birth control pills? .....            | yes | no |

Is there any condition or problem that you think we should know about?

\_\_\_\_\_

\_\_\_\_\_

Comments:

\_\_\_\_\_

\_\_\_\_\_

**ALL PATIENTS: PLEASE READ AND SIGN THE FOLLOWING STATEMENT.**

I hereby certify that I answered the above questions truthfully, to the best of my knowledge.

\_\_\_\_\_  
Signature of patient (or parent/legal guardian)

\_\_\_\_\_  
Date

Reviewed by: \_\_\_\_\_