# AESTHETIC DENTAL — Medical Health History

## DENTAL HISTORY

Reason for today's visit: ____________________ Date of last dental visit: ____________________
Former Dentist: ____________________ Date of last dental x-rays: ____________________

**Please fill in the circle if you have or had any of the following:**

- Bad breath O
- Blisters on lips or mouth O
- Burning sensation on tongue O
- Chew on one side of the mouth O
- Cigarette, pipe or cigar smoking O
- Smokeless tobacco O
- Dry mouth O
- Food collection between teeth O
- Clench teeth O
- Grind teeth O
- Growths or sore spots in mouth O
- Gums swollen, tender or bleeding O
- Head, neck or jaw pain or aches O
- Lip or cheek biting O
- Loose teeth or broken fillings O
- Mouth breathing O
- Orthodontic treatment O
- Nitrous Oxide O
- Periodontal treatment O
- Sensitivity to hot or cold O
- Sensitivity to pressure O
- Sensitivity to sweets O

How often do you floss? ____________
How often do you brush? ____________

Have you ever had an allergic reactions to Novocaine, local or general anesthetics? *If Yes, Please explain:*
____________________
____________________

Have you had trouble or issues from previous dental treatment? *If Yes, please explain what happened?*
____________________
____________________

## MEDICAL HISTORY

Physician's Name: ____________________ Address: ____________________
Date of last visit: ____________________ Have you had any serious illnesses or operations? _______ Yes _______ No
If Yes, please explain and give approximate dates: ____________________

**Please fill in the circle if you have or had any of the following:**

- Allergies, hay fever, sinusitis O
- Anemia O
- Arthritis, Rheumatism O
- Artificial Valves O
- Artificial Joints O
- Asthma O
- Asthma: Required Hospitalization O
- Asthma: Used Steroids O
- Bleeding abnormally with surgery O
- Blood Disease: Clotting Disorders O
- Cancer O
- Chemical Dependency O
- Chemotherapy O
- Circulatory Problems O
- Cortisone Treatments O
- Cough, persistent or bloody O
- Diabetes O
- Emphysema O
- Epilepsy or Seizures O
- Fainting O
- Glaucoma O
- Headaches O
- Heart Murmur O
- Hepatitis Type: ___________ O
- Herpes or Shingles O
- High Blood Pressure O
- Autoimmune Deficiency (HIV or AIDS) O
- Jaundice O
- Kidney Disease O
- Low Blood Pressure O
- Mitral Valve Prolapse O
- Osteoporosis O
- Pacemaker or Defibrillator O
- Pregnant or Nursing O
- Radiation Treatments O
- Respiratory Disease O
- Rheumatic Fever O
- Scarlet Fever O
- Shortness of Breath O
- Sinus Trouble O
- Sickle Cell Anemia O
- Skin Rash O
- Stroke O
- Swelling of Feet/Ankles O
- Thyroid Problems O
- Tonsillitis O
- Tuberculosis O
- Tumor or Growth on Head/Neck O
- Ulcers O
- Venereal Disease O
- Weight Loss, Unexplained O
- Do you wear contact lenses? O
- Do you consume alcohol or street drugs? O
- Are you currently under the care of a Physician? O
- Are you allergic to Latex or Metal? O
- Are you allergic to Penicillin, Sulfa drugs, Aspirin, Codeine or Tetracycline? O

*If Yes, please specify:* ________________
____________________

Are you currently taking any medications?
*If Yes, please list:* ____________________
____________________
____________________

## AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information may be hazardous or dangerous to my health.

Patient/Guardian Signature: ____________________ Date: ____________________

Reviewed by: ____________________ Date: ____________________