Richard G. Gross D.M.D.

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Name: _____

Reason for today's visit: _____

_____

Date of last dental visit? _____ Date of last dental X-rays? _____

Do you have or have you had any of the following? (Please check all that apply)

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Jaw pain/Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Orthodontic treatment
- ☐ Periodontal (gum) treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

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

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 Taking birth control pills? ☐ Yes ☐ No

Do you have or have you had any of the following? (Please check all that apply)

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cholesterol
- ☐ Circulatory Problems
- ☐ Congestive Heart Failure
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Headaches/Migraines
- ☐ Heart Murmur
- ☐ Heart Problems

Describe _____

- ☐ Mitral Valve Prolapse
- ☐ Hemophilia
- ☐ Hepatitis / Jaundice
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Skin Rash
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Venereal Disease

Is there any health information which was not asked, which you feel may influence your dental treatment?

_____

_____

_____

MEDICATIONS

List medications and supplements you are currently taking:

_____

_____

_____

ALLERGIES

- ☐ Asprin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin/Amoxicillin
- ☐ Sulfa
- ☐ 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 omissions that I may have made in the completion of this form.

Date: _____ Signature: _____