HOWARD Family Dental®

Patient's Name: ____

Dental History

Please check any of the following that apply to you:

- ❑ Sensitivity (hot, cold, sweets, pressure)
- ❑ Headaches, ear aches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or fillings breaking
- ❑ Grinding or clenching teeth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, chipped tooth/teeth
- ❑ Bad breath or bad taste in your mouth

What would you like to do to improve your smile?

- ❑ Whiten
- ❑ Straighten / Close spaces
- ❑ Replace silver fillings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns

Do you have or have you ever had any of the following?

- ❑ Dentures
- ❑ Partial Dentures
- ❑ Braces
- ❑ Periodontal (gum) treatments

What is the most important thing about your visit today?

____

____
Name of previous dentist

____
City & State

____
Phone number

Medical History

- ❑ Heart disease/murmur
- ❑ Liver/Hepatitis
- ❑ Kidney disease
- ❑ Diabetes
- ❑ Speech/hearing problems
- ❑ Cerebral palsy
- ❑ Cancer/tumor/growths
- ❑ Bleeding/transfusions/blood disorders
- ❑ High / Low Blood Pressure
- ❑ Anemia
- ❑ Seizures/Epilepsy
- ❑ Head/neck/back injuries
- ❑ Breathing problems/lung disease
- ❑ Anxiety/Depression
- ❑ HIV/AIDS
- ❑ Medications list
- ❑ Hospitalizations/surgeries/illnesses
- ❑ Pre-medicated
- ❑ Fainting/dizziness
- ❑ Artificial joints
- ❑ Tobacco user (currently)
- ❑ Glaucoma/eye problems
- ❑ Alcohol user (currently)
- ❑ Pregnancy (due date __/__/__)
- ❑ Radiation treatment/chemotherapy
- ❑ Arthritis/Rheumatism
- ❑ Sinus problems/hayfever
- ❑ Stroke/CNS/TIA
- ❑ Complication after dental treatment
- ❑ Pacemaker follow-up
- ❑ Stomach problems/ulcers/GI disease
- ❑ Osteoporosis
- ❑ Thyroid disease
- ❑ Organ transplant
- ❑ Marijuana or other street drugs
- ❑ Problems with Anesthesia
- ❑ On blood thinners
- ❑ Use C-Pap Machine at night

Are you taking any osteoporosis medications?

❑ Yes ❑ No

If yes, please list medications:

____

____

Do you have any allergies?

❑ No ❑ Yes ❑ Medications ❑ Latex

If yes, please list all allergies:

____

____

____

____

Please list any medications that you take or provide a list:

❑ I am currently NOT taking any medications.

____

____

____

____

____

____

____

____

____

____

Patient, Parent (or Guardian) signature: ______________________________________Date: ____________

Doctor signature: ____Date: ____________