PATIENTS NAME:_____BIRTHDATE:_____

# DENTAL HISTORY

REASONS FOR TODAY'S VISIT?_____

WHO WAS YOUR PREVIOUS DENTIST? NAME: _____PHONE NO:_____

WHEN WAS YOUR LAST DENTAL VISIT?_____WHAT WAS DONE?_____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE?_____

HAVE YOU HAD A FULL MOUTH SET OF XRAYS OR PANOREX? WHERE?_____WHEN?_____

HOW OFTEN DO YOU BRUSH YOUR TEETH?_____HOW OFTEN DO YOU FLOSS?_____

HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)?_____WHERE?_____WHEN?_____

# MEDICAL HISTORY UPDATE

*ALTHOUGH DENTAL PROFFESSIONALS PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS APART OF YOUR ENTIRE BODY. HEALTH PROBLEMS YOU MAY HAVE OR MEDICATIONS YOU ARE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTAL TREATMENT YOU MAY RECEIVE. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

PHYSICIAN'S NAME:_____ PHONE NUMBER:_____

HEIGHT:_____ WEIGHT:_____ **OFFICE USE ONLY: BP:_____ HEART RATE:_____**

DO YOU USE TOBACCO?_____ HOW MUCH/HOW OFTEN?_____

**FEMALE ONLY:** ARE YOU TAKING BIRTH CONTROL PILLS? YES____NO____ ARE YOU PREGNANT? YES___NO___

IF YES, # OF WEEKS_____ ARE YOU NURSING? YES_____NO_____

**PHARMACY**:_____ PHONE NUMBER:_____

| **MEDICATIONS** | **MEDICATIONS** | ALLERGIES: | Y | N |
|---|---|---|---|---|
| | | ASPIRIN | | |
| | | CLINDAMYCIN | | |
| | | CODEINE | | |
| | | DENTAL ANESTHETICS | | |
| | | ERYTHROMYCIN | | |
| | | JEWELRY | | |
| | | LATEX | | |
| | | METALS | | |
| | | PENICILLIN | | |
| | | SULFA | | |
| | | TETRACYCLINE | | |
| | | **OTHER:**_____ | | |

**(OVER PLEASE)**

**PLEASE CHECK ANY THAT APPLY:**

| | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|
| ABNORMAL BLEEDING | ☐ | ☐ | EPILEPSY | ☐ | ☐ | PSYCHIATRIC PROBLEMS | ☐ | ☐ |
| ALCOHOL ABUSE | ☐ | ☐ | FAINTING SPELLS | ☐ | ☐ | RADIATION THERAPY | ☐ | ☐ |
| ALLERGIES | ☐ | ☐ | FEVER BLISTERS | ☐ | ☐ | RHEUMATIC FEVER | ☐ | ☐ |
| ANEMIA | ☐ | ☐ | GLAUCOMA | ☐ | ☐ | RECREATIONAL DRUGS | ☐ | ☐ |
| ANGINA PECTORIS | ☐ | ☐ | HIV+AIDS | ☐ | ☐ | SEIZURES | ☐ | ☐ |
| ARTIFICAL BONES | ☐ | ☐ | HEART ATTACK | ☐ | ☐ | SHINGLES | ☐ | ☐ |
| ARTIFICIAL HEART VALVE | ☐ | ☐ | HEART MURMER | ☐ | ☐ | SICKLE CELL DISEASE | ☐ | ☐ |
| ASTHMA | ☐ | ☐ | HEART SURGERY | ☐ | ☐ | SINUS PROBLEMS | ☐ | ☐ |
| BLOOD TRANSFUSION | ☐ | ☐ | HEMOPHILIA | ☐ | ☐ | STROKE | ☐ | ☐ |
| CANCER-CHEMOTHERAPY | ☐ | ☐ | HEPATITIS A, B, OR C | ☐ | ☐ | TAKEN FEN-PHEN | ☐ | ☐ |
| COLITIS | ☐ | ☐ | HIGH BLOOD PRESSURE | ☐ | ☐ | THYROID PROBLEMS | ☐ | ☐ |
| CONGENITAL HEART DEFECT | ☐ | ☐ | KIDNEY PROBLEMS | ☐ | ☐ | TUBERCULOSIS | ☐ | ☐ |
| COSMETIC SURGERY | ☐ | ☐ | LIVER DISEASE | ☐ | ☐ | ULCERS | ☐ | ☐ |
| DIABETES | ☐ | ☐ | LOW BLOOD PRESSURE | ☐ | ☐ | VENERAL DISEASE | ☐ | ☐ |
| DIFFICULTY BREATHING | ☐ | ☐ | MITRAL VALVE PROLAPSE | ☐ | ☐ | YELLOW JAUNDICE | ☐ | ☐ |
| DRUG ABUSE | ☐ | ☐ | PACE MAKER | ☐ | ☐ | PINS/PLATES DATE_____ | ☐ | ☐ |
| EMPHYSEMA | ☐ | ☐ | PNEUMOCYSTITIS | ☐ | ☐ | VAPING | ☐ | ☐ |

**IS THERE ANY OTHER DISEASE, CONDITION, OR PROBLEM THAT YOU THINK THIS OFFICE SHOULD KNOW ABOUT THAT IS NOT COVERED ABOVE? YES ☐ NO ☐ PLEASE DESCRIBE BELOW:**

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY ABILITY. I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND THAT M.S. GINGRICH DDS AND HER STAFF WILL RELY ON THIS INFORMATION TREATING ME/MY MINOR CHILD. I WILL NOT HOLD MY DR. OR HER STAFF ACCOUNTABLE FOR ANY ACTION TAKEN OR NOT TAKEN DUE TO ERRORS OR OMISSIONS I MAY OF MADE WHILE COMPLETING THIS FORM.

SIGNATURE:_____ DATE:_____

(IF UNDER 18, PARENT OR GURDIAN SIGNUATURE REQUIRED)