Aronimink Dental Health

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DENTAL HEALTH HISTORY

(confidential)

Today's Date: _____

Patient's Name: _____ Birthdate: _____
Last First Initial

DENTAL HISTORY

Reason for Today's visit: _____ _____

Former Dentist: _____ _____

Address: _____ _____

Date of last dental care: _____ Date of last dental X-rays _____

Check [✔] if you have had any problems with any of the following

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

How often to you floss? _____ How often to you brush? _____

MEDICAL HISTORY

Physician's name: _____ Data of Last Visit: _____ _____

Have you had any serious illnesses or operations: _____ If yes describe: _____ _____

Have you had blood transfusion: _____If yes, give approximate dates: _____ _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing: ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check [✔] if you have or have had any of the following

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hearth Murmur
- ☐ Hearth Problems
  Describe _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name: _____

Phone: _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

SIGNATURE

The above information is accurate and complete to the best of may knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

Date: _____ Signature: _____ ____