LEE PLAZA DENTAL HEALTH HISTORY

Confidential

Current Date:

Last Name: First Name: Middle Int. Birth Date:

DENTAL HISTORY

Reason for Today's Visit: Date of last dental care:

Former Dentist: Date of last dental x-ray:

Address:

Check (√) if you have had 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 do you floss ? How often do you brush ?

MEDICAL HISTORY

Physican's Name: Date of Last Visit:

Have you had any serious illnesses or operations? Yes No If Yes, describe:

Have you ever had a blood transfusion? Yes No If Yes, give approximate dates:

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

Check (√) if you have had problems with any of the following:

- 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
- Heart Murmurs
- Heart Problems
- Hemophilia
- Hepatitis
- High Blood Pressure
- HIV/AIDS
- Jaw Pain
- Kidney Disease
- Liver Disease
- Mitral Valve Prolapse
- Pace Maker
- 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 of medications you are currently taking:

Pharmacy Name:

Phone Number:

ALLERGIES

- Aspirin
- Barbituates (Sleeping Pills)
- Codeine
- Jaw Pain
- Penicillin
- Sulfa
- Latex
- Other

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signed By: Electronic Signature Field: Date: