university family dental

Comprehensive, experienced care for exceptional outcomes.

Patient Dental History: Patient Name: _____

What is your primary reason for your visit today? _____

When was your last dental visit? _____ Name of Dentist: _____

Have your previous dental experiences been favorable? Yes / No If not, please explain:_____

Have you experienced any of the following?:
(check all that apply)

☐ Sensitivity to hot/cold	☐ Sensitivity to sweet/sour	☐ Sensitivity to pressure/biting
☐ Bleeding gums	☐ Sores of lumps in or around your mouth	☐ Gum recession
☐ Periodontal treatment	☐ Cracked or broken teeth	☐ Root Canal treatment
☐ Frequent headaches	☐ Habitual grinding or clenching of teeth	☐ Jaw pain/clicking or popping
☐ Crooked teeth	☐ Orthodontic treatment	☐ Discolored teeth

Medical History: Name of Physician: _____ Phone #: _____

Are you currently under medical treatment?: Y/N, if so please explain: _____

_____

Do you currently smoke or use other tobacco products? Y/N, if so how often? _____

Please list all current medications: _____

_____

Do you have any known allergies including any medications, antibiotics, narcotics, food, metals, or latex? Y/N
If so, please list:

_____

_____

(Check all that apply)

☐ Aids/HIV	☐ Anemia	☐ Angina/Chest Pain	☐ Artificial Joints/Implants
☐ Asthma/Respiratory Problems	☐ Bleeding Problems	☐ Cancer	☐ Chemotherapy
☐ Diabetes	☐ Dizziness/Fainting	☐ Epilepsy/Seizures	☐ Emphysema/COPD
☐ Glaucoma/Cataracts	☐ Heart Attack	☐ Heart Disease	☐ Heart Murmur
☐ Hepatitis	☐ Herpes	☐ High Blood Pressure	☐ Jaundice
☐ Kidney Disease	☐ Liver Disease	☐ Pacemaker	☐ Psychiatric Care
☐ Pregnancy	☐ Sleep Apnea/CPAP	☐ Stomach issues/Ulcers	☐ Stroke
☐ Thyroid	☐ Tuberculosis	☐ Other: _____	

I have read and understand the above information and have answered truthfully to the best of my knowledge. I understand that providing incorrect information may be dangerous to my medical/dental health.

Printed Name: _____ **Signature:** _____ **Date:** _____