Name:_____ Date:_____

DENTAL HISTORY

PLEASE CIRCLE as relates to your tooth.

_ Pain (present) _ Pain (past) _ No pain _ Can localize pain

_ Headache _ Earache _ Swelling _ Gum tenderness

_ Hot sensitive _ Cold sensitive _ Air sensitive _ Biting/touch sensitive

How long have you been in pain? _____ How long does it last?_____

Pain is _ constant, _ comes & goes, _ spontaneous, _ radiating, _ severe, _ dull ache, _throbs

Additional information:_____

_____

MEDICAL HISTORY

Physician's name: _____

Have you had any serious illnesses or operations? YES / NO

If yes, describe _____

Are you currently under a physician's care? YES /NO If yes describe _____

_____

List medications you are currently taking _____

_____

Are you allergic to: ASPIRIN, IBUPROFEN, LATEX, NOVOCAINE, PENICILLIN,

OTHER: _____

PLEASE CIRCLE if you have or have had any of the following:

_ Anemia
_Arthritis
_Artificial Heart Valve
_Artificial Joints
_Asthma
_Blood Disease
_Cancer
_Chemotherapy
_Cough, Persistent
_Diabetes
_Epilepsy
_Glaucoma
_Headaches
_Heart Murmur
_Heart Problems
_HIV/AIDS
_Abnormal Bleeding
_Hepatitis A, B, or C
_High Blood Pressure
_Kidney disease
_Liver Disease
_Mitral Valve Prolapse
_Radiation Treatment
_Respiratory Disease
_Rheumatic Fever
_Sinus Problems
_Stroke
_Surgical Implant
_Thyroid Disease
_Tuberculosis
_Ulcer/Colitis
_Pacemaker/Heart surgery
_Presently Pregnant

OTHER:

_____

SIGNATURE _____