

**DENTAL HISTORY**

Reason for today's visit? \_\_\_\_\_

Former Dentist: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Do you use tobacco products? Y or N Type: \_\_\_\_\_ How often: \_\_\_\_\_  
circle

**PLEASE INDICATE IF YOU HAVE HAD ONE OF THE FOLLOWING:**

- |  |   |
|--|---|
| <input type="checkbox"/> BAD BREATH                    | <input type="checkbox"/> LOOSE TEETH OR BROKEN FILLINGS |
| <input type="checkbox"/> BLEEDING GUMS                 | <input type="checkbox"/> MOUTH BREATHING                |
| <input type="checkbox"/> BURNING SENSATION ON TONGUE   | <input type="checkbox"/> MOUTH PAIN w/BRUSHING          |
| <input type="checkbox"/> BLISTERS ON LIPS OR MOUTH     | <input type="checkbox"/> ORAL APPLIANCE                 |
| <input type="checkbox"/> CHEW ON ONE SIDE OF MONTH     | Type: _____   |
| <input type="checkbox"/> CLICKING OR POPPING IN JAW    | <input type="checkbox"/> ORTHONDONTIC TREATMENT         |
| <input type="checkbox"/> DRY MOUTH                     | <input type="checkbox"/> PAIN AROUND EAR                |
| <input type="checkbox"/> FINGERNAIL BITING             | <input type="checkbox"/> PERIODONTAL TREATMENT          |
| <input type="checkbox"/> FOOD COLLECTION BETWEEN TEETH | <input type="checkbox"/> SENSITIVITY TO COLD OR HOT     |
| <input type="checkbox"/> GRINDING TEETH                | <input type="checkbox"/> SENSITIVITY TO SWEETS          |
| <input type="checkbox"/> GUMS SWOLLEN/TENDER           | <input type="checkbox"/> SENSITIVITY WHEN BITING        |
| <input type="checkbox"/> JAW PAIN OR FATIGUE           | <input type="checkbox"/> SORES OR GROWTH IN MOUTH       |
| <input type="checkbox"/> LIP OR CHEEK BITING           |   |

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine) Pondimin (fenfluramin) and Redux (dexfenfluramine.)

Yes       No

Have you ever been diagnosed as having a chemical dependency or feel that you are chemically dependant?

Yes    No   If so, how long have you been in recovery? \_\_\_\_\_

Have you had any of these drugs in the last 24 hours?

Cocaine       Ecstasy       Methamphetamine