TRISTAN GALLOWAY, DDS

Your Neighborhood Family Dentist

DENTAL HISTORY:

Name:_____ Date:_____

Reason for today's visit:_____

Former dentist name:_____ How often do you floss?_____

Date of last dental care:_____ How often do you brush?_____

Date of last dental x-rays:_____

Check if you have or had problems with any of the following:

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

MEDICAL HISTORY:

Physician's Name:_____ Date of last visit:_____

Have you had any serious illness or operations? ☐ Yes ☐ No

If yes, please describe:_____

Female's only: Pregnant? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Check if you have or have had any of the following:

- ☐ Acid Re-flux Disease
- ☐ Anemia
- ☐ Arthritis, rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints, pins, etc.
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding abnormally
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart problems
- ☐ Cough, persistent
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia repair
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Recreational drug use
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Pacemaker
- ☐ Radiation treatments
- ☐ Respiratory disease
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ No Medical Conditions

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list the medications you are currently taking and the correlating diagnosis:_____

_____

_____

Any allergies? ☐ Yes (please list below) ☐ No

If yes, please list the allergy and the reactions:_____

_____

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.

_____ _____

Signature of patient, guardian or personal representative Date