CRANBERRY
FAMILY DENTISTRY
20215 Route 19 Suite 100 Cranberry Twp, PA 16066 724.742.1700 P 724.742.1722 F

Dental Health History (Confidential)

Date: _____

Patient Name: _____ *Birthdate:* _____
last first MI

DENTAL HISTORY

Reason for today's visit? _____

Former Dentist: _____

Address: _____

Date of last dental care: _____ Date of last dental X-rays: _____

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

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaws
- ❑ Food collection bettween teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

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

Have you had any serious illness or operations? _____ 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:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Depenfency
- ❑ Chemotherapy
- ❑ Circulatory Probems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
  Describe: _____
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Problems
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet/Ankle
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

MEDICATIONS

List medications you are currently taking: _____

_____

_____

Pharmacy Name: _____

Phone: _____

ALLERGIES

- ❑ Aspirin
- ❑ Barbiturates (Sleeping Pills)
- ❑ Codeine
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Latex
- ❑ Other: _____

_____

_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ *Signature:* _____