

Maple Valley Dentistry Professionals

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Gentle quality dentistry for the entire family

Name _____ Date _____

Dental History

Reason for Today's Visit _____

Previous Dentist _____

Address _____

Date of last dental visit _____ Date of last dental X-rays _____

Indicate if you have any of the following conditions

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Grinding Teeth	<input type="checkbox"/> Sensitivity to Hot
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Loose Teeth or Broken Fillings	<input type="checkbox"/> Sensitivity to Sweets
<input type="checkbox"/> Clicking or Popping Jaw	<input type="checkbox"/> Periodontal Treatment	<input type="checkbox"/> Sensitivity to Biting
<input type="checkbox"/> Food Collection Between Teeth	<input type="checkbox"/> Sensitivity to Cold	<input type="checkbox"/> 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 illnesses or operations? Yes No If yes, 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

Indicate if you have any problems with any of the following:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Cough up Blood	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Swelling of Feet or Ankles
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Headache	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemotherapy Describe _____		<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Venereal Disease

MEDICATIONS

List all medications that you are currently taking:

ALLERGIES

Verification

I verify that the medical history information provided above to be complete and accurate.

I understand that I am responsible for any errors of omissions as well as updating the dentist on any future changes in my medical history.

Signature _____ Date _____