


Dental Health History

Basic Information			
Patient Name Annabelle Lewis		Date of Birth 12/16/1990	Email annalewis@gmail.com
Address 123 Sample Street		Contact Number 986-100	
Dental History			
Reason for Today's Visit General Checkup			
Former Dentist Name Roger Smith		Email annalewis@gmail.com	Contact Number 986-100
Date of Last Dental Care 2/13/2021	Date of Last Dental X-rays 2/13/2021	Flossing Frequency Once/day	Brushing Frequency Twice/day
Select any of the following problems you have or have had			
<input type="checkbox"/> Bad Breath	<input checked="" type="checkbox"/> Grinding Teeth	<input type="checkbox"/> Sensitivity to Hot	
<input checked="" 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 when Biting	
<input type="checkbox"/> Food Collection Between Teeth	<input checked="" type="checkbox"/> Sensitivity to Cold	<input type="checkbox"/> Sores or Growths in Your Mouth	
Medical History			
Physician Name Helen Russell		Email helenr@gmail.com	Date of Last Visit 09/22/2022
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, what was the approximate date:			
Are you pregnant? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Nursing? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Taking birth control pills? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Select any of the following that you have or have had			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Cough up Blood	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Stroke
<input checked="" type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Swelling of Feet or Ankles
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
List any other serious illnesses or operation that you have or have had N/A			
List any current medications N/A		List any allergies N/A	
All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.			
Parent, Guardian or Personal Representative Name (Printed)		Relationship to Patient (If Applicable)	
Signature of Patient, Parent, Guardian or Personal Representative 		Date 10/22/2022	

Dental History Form Template

Arun K. Garg



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