Bradford J. Rhodes, D.M.D.

DENTAL HEALTH HISTORY (CONFIDENTIAL)

Today's date:

DENTAL HISTORY

Patient's last name:	First:	Middle:	Birth date: / /

Reason for today's visit:

Former dentist:

Address:

Date of last dental care:	Date of last dental x-rays:

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

❑ Bad breath	❑ Grinding teeth	❑ Cold sores or fever blisters
❑ Bleeding gums	❑ Loose teeth or broken fillings	❑ Sensitivity to sweets
❑ Clicking or popping jaw	❑ Periodontal treatment	❑ Sensitivity when biting
❑ Food collection between teeth	❑ Sores or growths in your mouth	❑ Sensitivity to hot or cold

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

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

❑ AIDS or HIV positive	❑ Chemo or radiation therapy	❑ Heart murmur	❑ Psychiatric care
❑ Anemia	❑ Circulatory problems	❑ Hemophilia	❑ Respiratory disease
❑ Arthritis, Rheumatism	❑ Cortisone treatments	❑ Hepatitis	❑ Rheumatic fever
❑ Artificial heart valves	❑ Cough, persistent	❑ High blood pressure	❑ Scarlet fever
❑ Artificial joints or implants	❑ Diabetes	❑ Jaw pain	❑ Stroke
❑ Asthma	❑ Epilepsy or seizures	❑ Kidney disease	❑ Thyroid problems
❑ Back problems	❑ Fainting or dizzy spells	❑ Liver disease	❑ Tobacco habit
❑ Blood disease	❑ Glaucoma	❑ Mitral valve prolapse	❑ Tuberculosis
_____	❑ Headaches	❑ Nervous problems	❑ Ulcer
❑ Cancer	❑ Heart failure, disease, or attack	❑ Osteoporosis	❑ Venereal disease
❑ Chemical dependency	_____	❑ Pacemaker	❑ Other _____

MEDICATIONS

Please list prescription or non-prescription medications:

Pharmacy:	Phone:

ALLERGIES

❑ Aspirin	❑ Local anesthetic
❑ Barbiturates (sleeping pills)	❑ Penicillin
❑ Codeine	❑ 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 staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:	Date: