ELLIFF DENTAL
FAMILY & COSMETIC DENTISTRY

Patient Name____ Date of Birth________________

Dental History

Are you in dental discomfort today? ____
Former Dentist______________________________ Phone_____________________________
Date of last dental care _______________________ Date of last x-rays __________________

Circle Y/N if you have had any of the following:

Y/N	Bad Breath	Y/N	Sensitivity to cold / hot	Y/N	Food collection between teeth
Y/N	Sensitivity when biting	Y/N	Periodontal treatment	Y/N	Clicking or popping jaw
Y/N	Sensitivity to sweets	Y/N	Loose teeth or broken fillings	Y/N	Bleeding gums
Y/N	Sores or growth in mouth	Y/N	Grinding or clenching teeth	Y/N	Jaw Pain

How often do you brush? _________________________Floss? _________________________
How do you feel about the appearance of your teeth? ___________________________________
Ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y/N
If yes, explain ____
Other information about your dental health or previous treatment __________________________

Medical History

Physician's Name _____________________________ Phone # ________________ Date of last visit ___________
Have you ever had any serious illnesses or operations? Y/N If yes, describe________________________________
Are you currently under physician care? Y/N If yes, describe ____
Have you ever been required to take antibiotics before a dental appointment? Y/N

Circle Y/N whether you have had any of the following:

Y/N	AIDS/HIV Positive	Y/N	Emphysema	Y/N	Pacemaker
Y/N	Alcoholism	Y/N	Epilepsy	Y/N	Psychiatric Care
Y/N	Anaphylaxis	Y/N	Glaucoma	Y/N	Radiation Treatment
Y/N	Anemia	Y/N	Headaches	Y/N	Rapid Weight Gain/Loss
Y/N	Arthritis, Rheumatism	Y/N	Heart Murmur	Y/N	Respiratory Disease
Y/N	Artificial Heart Valves	Y/N	Heart Problems	Y/N	Rheumatic/Scarlet Fever
Y/N	Artificial Joints (any type)	Y/N	Heart Surgery	Y/N	Seizure
Y/N	Asthma	Y/N	Hemophilia/Abnormal Bleeding	Y/N	Shortness of Breath
Y/N	Back Problems	Y/N	Herpes	Y/N	Spina Bifida
Y/N	Blood Disease	Y/N	Hepatitis (any form)	Y/N	Stroke
Y/N	Cancer or Tumors	Y/N	High Blood Pressure	Y/N	Surgical Implant
Y/N	Chemotherapy	Y/N	Kidney Disease or Malfunction	Y/N	Thyroid Disease (Hyper/Hypo)
Y/N	Circulatory Problems	Y/N	Liver Disease	Y/N	Tobacco Habit
Y/N	Cortisone Treatments	Y/N	Material Allergies (Latex, Metal)	Y/N	Tuberculosis
Y/N	Diabetes	Y/N	Mitral Valve Prolapse	Y/N	Ulcer/Colitis
Y/N	Eating Disorder (any form)	Y/N	Nervous Problem	Y/N	Venereal Disease (STDs)

Women only: Are you pregnant? Y/N Nursing? Y/N Taking birth control pills? Y/N

Are you currently taking any medications? Y/N If yes, please list all:
____
Do you have any drug allergies? Y/N If yes, please list all:
____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature ____ **Date** ____________________

Revised 8/15