OMNI DENTAL

Dental & Medical History Information

Patient Name: _____ Reason for today's visit: _____

Dental History:

Date of last dental visit: _____ Date of last x-rays: _____ How often do you brush? _____ Floss? _____

☐Yes ☐No Bad Breath	☐Yes ☐No Food collection between teeth	☐Yes ☐No Mouth pain, brushing
☐Yes ☐No Bleeding Gums	☐Yes ☐No Concerns with your smile	☐Yes ☐No Orthodontic treatment
☐Yes ☐No Blisters on lips or mouth	☐Yes ☐No Grinding teeth	☐Yes ☐No Pain around ear
☐Yes ☐No Burning sensation on tongue	☐Yes ☐No Gums swollen or tender	☐Yes ☐No Periodontal treatment
☐Yes ☐No Chew on one side of mouth	☐Yes ☐No Jaw pain	☐Yes ☐No Sensitivity to cold
☐Yes ☐No Cigarette/pipe/cigar smoking	☐Yes ☐No Jaw tiredness	☐Yes ☐No Sensitivity to heat
☐Yes ☐No Clicking or popping jaw	☐Yes ☐No Lip or cheek biting	☐Yes ☐No Sensitivity to sweets
☐Yes ☐No Dry mouth	☐Yes ☐No Loose teeth/broken fillings	☐Yes ☐No Sensitivity when biting
☐Yes ☐No Fingernail biting	☐Yes ☐No Mouth breathing	☐Yes ☐No Sores/growths in mouth

Medical History:

☐Yes ☐No AIDS/HIV	☐Yes ☐No Emphysema	☐Yes ☐No Radiation Treatment
☐Yes ☐No Anemia	☐Yes ☐No Epilepsy	When_____
☐Yes ☐No Arthritis, Rheumatism	☐Yes ☐No Fainting	☐Yes ☐No Respiratory Disease
☐Yes ☐No Artificial heart valves	☐Yes ☐No Glaucoma	☐Yes ☐No Rheumatic Fever
☐Yes ☐No Artificial joints	☐Yes ☐No Headaches	☐Yes ☐No Scarlet Fever
☐Yes ☐No Asthma, Use inhaler: ☐Yes ☐No	☐Yes ☐No Heart Murmur	☐Yes ☐No Shortness of breath
☐Yes ☐No Back Problems	☐Yes ☐No Heart problems explain:_____	☐Yes ☐No Sinus Trouble
☐Yes ☐No Bleeding abnormally,	☐Yes ☐No Hepatitis, Type_____	☐Yes ☐No Skin Rash
☐Yes ☐No Blood Disease	☐Yes ☐No Herpes	☐Yes ☐No Special diet
☐Yes ☐No Cancer, Type_____	☐Yes ☐No High Blood Pressure	☐Yes ☐No Stroke
☐Yes ☐No Chemical Dependency	☐Yes ☐No Low Blood Pressure	☐Yes ☐No Swollen feet/ankles
☐Yes ☐No Chemotherapy, When_____	☐Yes ☐No Liver Disease	☐Yes ☐No Swollen neck/glands
☐Yes ☐No Circulatory Problems	☐Yes ☐No Nervous Problems	☐Yes ☐No Thyroid Problems
☐Yes ☐No Venereal Disease	☐Yes ☐No Psychiatric Care	☐Yes ☐No Tonsillitis
☐Yes ☐No Tumors	☐Yes ☐No Weight loss/gain	☐Yes ☐No Tuberculosis
☐Yes ☐No Ulcer	☐Yes ☐No Diabetes	☐Yes ☐No Dizziness

Women Only: ▪Are you pregnant? ☐ Yes ☐ No ▪Are you taking birth control pills? ☐ Yes ☐ No

Medications

List any medications your are currently taking:

_____

_____

Allergies

☐ Aspirin ☐ Latex ☐ Tetracycline ☐ Other:_____

☐ Codeine ☐ Metals ☐ Penicillin _____

☐ Sulfa ☐ Erythromycin ☐ Dental Anesthetics

To the best of my knowledge, I have answered every question completely and accurately, I will inform my dentist of any change in my health and/or medication.

Patient Signature:_____ Date: ____/____/_____.