



Donald J. Johnson, DDS

Name: _____ Birth Date: _____

DENTAL HISTORY

Reason for today's visit: _____ Date of last dental exam: _____

Name of former Dentist: _____ Ph () _____ Date of last xrays: _____

Check if you've had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to pressure/biting |
| <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"/> Sores or growths in your mouth |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to hot/cold | |

How often do you brush? _____ X Day How often do you floss? _____ X Day Week Month Never

Other Concerns: _____

MEDICAL HISTORY

Physican: _____ Date of last physical exam: _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Any heart problems | <input type="checkbox"/> Head Aches | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia or other blood problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Artificial Joint(s) Date _____ | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Mitral Valve Prolapse | WOMEN ONLY |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Pregnant (Due _____) |
| <input type="checkbox"/> Excessive bleeding from cuts | <input type="checkbox"/> Respiratory Disease | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | |

Allergy to any drugs (please list) _____

Allergy to any anesthetics (please list) _____

List all medications you are taking _____

Do you take aspirin? _____

If there are ANY changes in my medical history, I will notify the dentist.

Signature: _____ Date: _____

Updated: _____ Updated: _____ Updated: _____ Updated: _____