SCHOMMER DENTAL MEDICAL/DENTAL HISTORY

Name_____ DOB_____

Date of last dental visit_____ Date of last x-rays_____
Former Dentist_____ City/State_____
How often do you: **Brush**_____ times per_____ **Floss**_____ **times per**_____
How do you feel about dental treatment? **RELAXED** **UNEASY** **TENSE** **ANXIOUS**

Do you have or have you ever had any of the following?

☐ Aching or sensitive teeth ☐ Areas of food traps ☐ Sensitive or bleeding gums ☐ Clicking/popping in jaw
☐ Difficulty opening wide ☐ Bad Breath ☐ Grinding or clenching ☐ Swollen glands
☐ Gum infection ☐ Jaw pain ☐ Broken or missing teeth ☐ Orthodontic treatment
☐ Dry mouth ☐ Cold sores ☐ Loose teeth ☐ Other_____

Do you snore? ☐ yes ☐ no

Name of Physician_____ Date of last visit_____
Are you allergic to or have reactions to any of the following:

☐ Local anesthetics like Novocain ☐ Penicillin or other antibiotics ☐ Latex ☐ Sulfa drugs ☐ Fluoride
☐ Aspirin or other pain medications ☐ Metals ☐ Acrylic ☐ Other_____
Women are you: ☐ Pregnant/trying to get pregnant ☐ Taking oral contraceptives ☐ Nursing

Do you have, or have you ever had, any of the following:

☐ AIDS/HIV
☐ Alcohol/Drug Dependency
☐ Anemia
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Arthritis
☐ Blood Disease
☐ Cancer
☐ Congenital Heart Disorder
☐ Cortisone Medication
☐ Diabetes
☐ Digestive Disorders
☐ Difficulty swallowing
☐ Emphysema
☐ Epilepsy
☐ Frequent Headaches
☐ Glaucoma
☐ Heart Disease
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis (Type_____)
☐ High Blood Pressure
☐ HPV
☐ Hypoglycemia
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Radiation Treatment
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Sinus Problems
☐ Stroke
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumor
☐ Ulcers
☐ Other not listed
_____

To the best of my knowledge, the above information is correct.

Patient Signature_____ Date_____
Or Parent/Guardian if patient is under 18
Doctor's Signature_____ Date_____

Medical Health Update: Please verify changes in your health since your last dental visit.

Date	Changes in health	Are you taking any new medications?	Signature
_____	☐ yes ☐ no	☐ yes ☐ no	_____