David R. Englehart, D.M.D.
220 Regent Court, Suite D
State College, PA 16801

DENTAL HEALTH HISTORY
(CONFIDENTIAL)

Today's Date_____

Patient Name_____Birthdate____/____/____
Last First M/I

Dental History

Reason for Today's visit_____

Date of last dental care_____Date of last dental X-rays_____

Check (/) If you have had problems with any of the following…

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

How often do you floss?_____How often do you brush_____

Medications

List medications you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Pharmacy Name_____Phone #_____

Allergies

( ) Aspirin
( ) Barbiturates (sleeping pills)
( ) Codeine
( ) Local Anesthetic
( ) Penicillin
( ) Sulfa
( ) Other_____
_____

Patient's Name_____

Medical History

Physician's Name_____Date of Last Visit_____
Have you had any serious illnesses or operations?_____If yes, describe_____
Have you ever had a blood transfusion? ( ) Yes ( ) No
If yes, give approx. dates_____

(***Women***)
Are you pregnant? ( )Y ( )N Nursing? ( )Y ( ) N Taking birth control? ( ) Y ( ) N

Check ( ) if you have had any of the following:

( ) Aids
( ) Anemia
( ) Arthritis
( ) Artificial Heart Valves
( ) Artificial Joints
( ) Asthma
( ) Back Problems
( ) Blood Disease
( ) Cancer
( ) Chemical Dependency
( ) Chemotherapy
( ) Circulatory Problems
( ) Cortisone Treatments
( ) Cough up Blood
( ) Diabetes
( ) Epilepsy
( ) Fainting
( ) Glaucoma
( ) Headaches
( ) Heart Murmur
( ) Heart Problems
describe_____
( ) Hemophilia
( ) Hepatitis
( ) High Blood Pressure
( ) HIV Positive
( ) Jaw Pain
( ) Kidney Disease
( ) Liver Disease
( ) Mitral Valve Prolapse
( ) Nervous Problems
( ) Pacemaker
( ) Psychiatric Care
( ) Radiation Treatment
( ) Respiratory Disease
( ) Rheumatic Fever
( ) Scarlet Fever
( ) Shortness of Breath
( ) Skin Rash
( ) Stroke
( ) Swelling of Feet or Ankles
( ) Thyroid Problems
( ) Tobacco Habit
( ) Tonsillitis
( ) Tuberculosis
( ) Ulcer
( ) Venereal Disease

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____Signature_____