321 N. Breiel Blvd. 513-424-3971
Middletown, OH 45042

2309 Woodman Dr. 937-252-9070
Kettering, OH 45420

Garland & Johnson Dental

DENTAL / MEDICAL HISTORY

Former Dentist _____ City, State _____ Last Dental visit date _____

Date of last Oral X-rays _____ How often do you floss? _____ How often do you brush? _____

Check all that apply:

Bad Breath	❒Yes ❒No	Loose teeth or broken filling	❒Yes ❒No	Sensitivity to sweets	❒Yes ❒No
Bleeding gums	❒Yes ❒No	Orthodontic Treatment	❒Yes ❒No	Sensitivity when biting	❒Yes ❒No
Blisters on lip/mouth	❒Yes ❒No	Pain around ear	❒Yes ❒No	Frequent headaches	❒Yes ❒No
Fingernail biting	❒Yes ❒No	Periodontal Treatment	❒Yes ❒No	Jaw, head or neck injuries	❒Yes ❒No
Grinding teeth	❒Yes ❒No	Sensitivity to cold	❒Yes ❒No	Jaw clicking and/or pain	❒Yes ❒No
Lip and cheek biting	❒Yes ❒No	Sensitivity to heat	❒Yes ❒No	Tooth pain	❒Yes ❒No

Physician's Name _____ Date of last visit _____

1. Are you currently under medical treatment? ❒Yes ❒No
2. Have you ever had any serious illnesses? ❒Yes ❒No
3. Have you ever had any serious operations? ❒Yes ❒No
4. Are you currently taken medications? ❒Yes ❒No
   Please list your medications: _____
   _____
5. Do you smoke? ❒Yes ❒No
6. Do you use cocaine or other illicit drugs? ❒Yes ❒No
7. Do you wear contact lenses? ❒Yes ❒No
8. (Women only) Are you:
   - Pregnant ❒Yes ❒No
   - Nursing ❒Yes ❒No
   - Taking birth control ❒Yes ❒No

9. Have you had allergic reactions to the following:

Local Anesthetics	❒Yes ❒No
Penicillin or other Antibiotics	❒Yes ❒No
Sulfa Drugs	❒Yes ❒No
Barbiturates (sleeping pills)	❒Yes ❒No
Sedatives	❒Yes ❒No
Iodine	❒Yes ❒No
Aspirin	❒Yes ❒No
Latex	❒Yes ❒No

Other: _____
_____
_____

Check all that apply:

AIDS	❒Yes ❒No	Diabetes	❒Yes ❒No	Nervous Problems	❒Yes ❒No
Anemia	❒Yes ❒No	Emphysema	❒Yes ❒No	Pacemaker	❒Yes ❒No
Arthritis	❒Yes ❒No	Epilepsy	❒Yes ❒No	Psychiatric care	❒Yes ❒No
Artificial Heart Valves	❒Yes ❒No	Fainting/Dizzy	❒Yes ❒No	Radiation	❒Yes ❒No
Artificial Joints	❒Yes ❒No	Glaucoma	❒Yes ❒No	Respiratory	❒Yes ❒No
Asthma	❒Yes ❒No	Headaches	❒Yes ❒No	Rheumatic Fever	❒Yes ❒No
Back Problems	❒Yes ❒No	Heart Murmur	❒Yes ❒No	Scarlet Fever	❒Yes ❒No
Bleeding abnormally,	❒Yes ❒No	Heart Problems	❒Yes ❒No	Shortness of breath	❒Yes ❒No
with surgery/extractions	❒Yes ❒No	Hepatitis	❒Yes ❒No	Sinus Trouble	❒Yes ❒No
Blood Disease	❒Yes ❒No	Herpes	❒Yes ❒No	Skin Rash	❒Yes ❒No
Cancer	❒Yes ❒No	High Blood Pressure	❒Yes ❒No	Stroke	❒Yes ❒No
Chemical Dependency	❒Yes ❒No	HIV Positive	❒Yes ❒No	Swelling of feet/ankles	❒Yes ❒No
Chemotherapy	❒Yes ❒No	Jaundice	❒Yes ❒No	Swollen Neck Glands	❒Yes ❒No
Chronic Fatigue Synd.	❒Yes ❒No	Jaw Pain	❒Yes ❒No	Thyroid Problems	❒Yes ❒No
Circulatory problems	❒Yes ❒No	Kidney Disease	❒Yes ❒No	Tonsillitis	❒Yes ❒No
Congenital Heart Issues	❒Yes ❒No	Liver Disease	❒Yes ❒No	Tuberculosis	❒Yes ❒No
Cortisone Treatment	❒Yes ❒No	Low Blood Pressure	❒Yes ❒No	Tumor/growth on head	❒Yes ❒No
Cough-persistent	❒Yes ❒No	Mitral Valve Prolapse	❒Yes ❒No	Ulcer	❒Yes ❒No
Had Bisphosphonates	❒Yes ❒No	Venereal Disease	❒Yes ❒No	Human Papilloma Vaccine	❒Yes ❒No

Please advise us in the future of any change in your dental or medical history or any medications you may be taking.

Signature Patient/Guardian _____ Date _____

Witness Signature _____ Date _____