LIBRARY PLAZA DENTAL CENTER
FAMILY, COSMETIC, & IMPLANT DENTISTRY

Name _____

Date ____/____/____

DENTAL & MEDICAL HISTORY **Birthdate** ____/____/____

Reason for today's visit _____ Date of last exam _____/_____/_____

How often do you brush? _____ Floss? _____ Mouthwash (type)? _____

Do you have any dental problems or history of an upsetting dental experience? ☐ Yes ☐ No

Describe _____

Have you ever had? ☐ Orthodontics ☐ Oral Surgery ☐ Periodontal Surgery

Please check any of the following conditions that apply to you:

☐ Bad breath
☐ Bleeding gums
☐ Clicking / popping jaw
☐ Food collection
☐ Sore facial muscles
☐ Difficulty opening / closing
☐ Loose teeth
☐ Broken tooth / filling
☐ Periodontal treatment
☐ Sores / growths in mouth
☐ Sensitivity to hot / cold / sweet
☐ Sensitivity when biting
☐ Dry mouth
☐ Grinding teeth / night guard
☐ Headaches or neck aches
☐ Other _____

Physician _____ Date of Last Visit _____/_____/_____

Current Medications and Reason For Taking _____

List all allergies _____

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Please indicate which of the following you have had or currently have: (Check all that apply)

☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Artificial heart valves
☐ Asthma
☐ Back problems
☐ Blood thinners
☐ Cancer
☐ Chemical dependency
☐ Chemotherapy
☐ Clotting disorder
☐ Cold sores
☐ Diabetes Type I / II
☐ Epilepsy
☐ Glaucoma
☐ Headaches
☐ Heart murmur / problems
☐ Hemophilia
☐ Hepatitis
☐ High blood pressure
☐ HIV/AIDS
☐ Joint replacement
☐ Kidney trouble
☐ Pacemaker
☐ Rheumatic fever
☐ Sinus problems
☐ Steroid treatments
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ Other/Describe above _____

Do you smoke? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No Use recreational drugs? ☐ Yes ☐ No

Have you had surgery or been hospitalized in the last 10 years? ☐ Yes ☐ No Describe: _____

Patient Signature _____ **Date** ____/____/____

1533 Ellinwood Ave | Des Plaines, IL 60016 | www.LibraryPlazaDental.com | 847-297-0808 | LPdentalcenter@gmail.com