WOLF DDS
general, cosmetic & implant dentistry for adults

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DENTAL HISTORY

Reason for Today's Visit: _____

Date of the Last Dental Visit: _____

Former Dentist's Name: _____

Address: _____
Street Town State Zip

Phone: ( ) _____

Do you have severe anxiety about dental treatment? Yes ☐ No ☐

Have you ever had an adverse reaction to dental treatment? Yes ☐ No ☐

If **Yes**, please explain: _____

HEALTH HISTORY

Physician's Name _____

Address: _____
Street Town State Zip

Phone: ( ) _____

Date of last physical exam: _____

Are you currently being treated by a physician? Yes ☐ No ☐

*If **Yes**, please explain:* _____

Have you been admitted to a hospital or had emergency care in the past two years? Yes ☐ No ☐

*If **Yes**, please explain:* _____

Are you currently taking any medications, including oral contraceptives or aspirin? Yes ☐ No ☐

*If **Yes**, please list:* _____

Have you had an allergic reaction? Yes ☐ No ☐

*If **Yes**, please list all allergies:* _____

Do you currently use tobacco? Yes ☐ No ☐ *If **Yes**, for how many years?* _____

*If **No**, have you used tobacco in the past?* Yes ☐ No ☐ *If **Yes**, for how many years?* _____ *When did you quit?* _____

Do you consume alcoholic beverages? Yes ☐ No ☐ *If **Yes**, how often?* _____

Do you have any history of the following diseases or conditions?

Anemia	☐	Fainting	☐	Liver Disease	☐
Anxiety / Depression	☐	Gastrointestinal Disorders	☐	Lyme Disease	☐
Arthritis	☐	Hearing Loss	☐	Migraines / Headaches	☐
Asthma / Hey Fever	☐	Heart Attack / Stroke	☐	Neurological Condition	☐
Autism	☐	Heart Disease	☐	Nutritional Deficiency	☐
Back Problems	☐	Hear Murmur	☐	Orthopedic Problems	☐
Bleeding Disorder	☐	Hepatitis: Type	☐	Rheumatic Fever	☐
Brain Injury	☐	Herpes	☐	Sickle Cell Trait or Disease	☐
Cancer: Type	☐	High Blood Pressure	☐	Syndrome: Type	☐
Cerebral Palsy	☐	High Cholesterol	☐	Scoliosis	☐
Cleft Lip / Palate	☐	HIV Infections (AIDS)	☐	Thyroid Condition	☐
Diabetes: Type	☐	Hypertension	☐	Transfusion of Blood	☐

Other conditions we should be aware of: _____

Women Only:

Are you Pregnant? Yes ☐ No ☐ Are you Nursing? Yes ☐ No ☐

To the best of my knowledge, all of the preceding information is accurate. I understand that it is my responsibility to inform the Doctors and his staff, if in the future, I have a change in my health status, including changes in my medications and/or allergies.

Patient's Name _____

Signature _____ Date _____