W O L F
DENTAL

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general, cosmetic & implant dentistry for adults

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DENTAL HISTORY

Reason for today's visit: _____ Date of last Dental visit: _____

Former Dentist's Name: _____ 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: _____

Physician's Phone: _____

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? 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?*_____

Do you use vaping products? Yes ☐ No ☐ *if Yes, for how many years?*_____

If No, have you used them in the past? Yes ☐ No ☐ *if Yes, for how many years?*_____

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

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

Alzheimer's/Dementia ☐	Depression ☐	Lyme Disease ☐
Anemia ☐	Diabetes Type_____ ☐	Migraines/Headaches ☐
Anxiety ☐	Gastrointestinal Disorder ☐	Motor disability ☐
Arthritis ☐	GERD ☐	Neurological Condition ☐
Asthma/Hay Fever ☐	Hearing Loss ☐	Nutritional Deficiency ☐
Autism ☐	Heart Disease ☐	Orthopedic Problems ☐
Bleeding Disorder ☐	Hepatitis Type_____ ☐	Prosthetic Cardiac Valve ☐
Bulimia/Eating Disorder ☐	Herpes ☐	Sickle Cell Trait or Disease ☐
Cancer Type_____ ☐	High Blood Pressure ☐	Stroke ☐
Cleft Lip/Palate ☐	High Cholesterol ☐	Syndrome: Type_____ ☐
Clostridium Difficile ☐	HIV Infections (AIDS) ☐	Transfusion of Blood ☐
Congenital Heart Defect ☐	Infective Endocarditis ☐	Thyroid Condition ☐
	Liver Diseases ☐	Vertigo ☐

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 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: _____