Hilltop Dentists
Patient History

DENTISTS COMMENTS/CONCERNS

1. Reason of Initial Visit _____
2. How Long Since Your Last Dental Visit? _____
3. How Do You Feel About Your Teeth in General? _____
4. Are you happy with the appearance of your teeth? YES ☐ NO ☐
   If NO, Explain _____
5. Have you had any unpleasant dental experiences? YES ☐ NO ☐
   If YES, Explain _____
6. What is your biggest concern? _____
7. Have you had any previous dental work done? If Yes, Explain…

   _____

   _____
8. Do you Clench or grind your teeth? YES ☐ NO ☐
9. Have you ever been hospitalized or had a major operation? YES ☐ NO ☐
10. Are you taking any medication? If Yes, Please list them.

    _____

    _____
11. Do you use any Tobacco Products? If Yes, how many/much per day? _____
12. Do You consume alcoholic beverage? If Yes, How many per day? _____
13. Are you allergic to any of the following? (please circle which ones)
    Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Local Anesthetics
    Others: _____
14. Do you or have you ever had any of the following? (please circle)
    AIDS/HIV Positive Hepatitis B or C High Cholesterol Excessive Thirst
    Sinus Trouble Frequent Headaches Cancer Cold Sores/Fever Blisters
    Heart Trouble/Disease Diabetes Anemia Artificial Heart Valve Asthma
    Blood Disease Stroke Chemotherapy Heart Murmur Hepatitis A
    High Blood Pressure Excessive Bleeding Fainting Spells/Dizziness
    Blood Transfusion Bruise Easily Mitral Valve Prolapse
    Pain in Jaw Joints Drug Addiction Epilepsy or Seizures Artificial Joint
    Irregular Heartbeat Breathing Problems Low Blood Pressure
    Heart Attack/Failure Pacemaker Chest Pains Kidney Problems
15. Have you ever had any serious illness not listed? If yes, please explain
16. Are you Pregnant? _____

Any Comments:

_____

Patient Signature, or Guardian Date: