Apelgren Dental
3938 Cedar Grove Pkwy.
Eagan, MN 55122
651-452-9660

DENTAL AND HEALTH HISTORY

Patient Name: ______________________

Address: ______________________

Reason for visit: ______________________ Date of last dental visit: ______________________

Former Dentist: ______________________ Date of last dental x-rays: ______________________

DENTAL HISTORY

____ Bad breath
____ Bleeding gums
____ Clicking or popping jaw
____ Food collection between teeth
____ Sores/growths in your mouth
____ Grinding teeth
____ Loose teeth
____ Periodontal treatment
____ Broken fillings
____ Previous orthodontics (braces)
____ Sensitivity to hot
____ Sensitivity to sweets
____ Sensitivity to biting
____ Sensitivity to cold

MEDICAL HISTORY

____ Anemia
____ Arthritis
____ Artificial heart valve
____ Artificial joints
____ Asthma
____ Bleeding disorder
____ Cancer
____ Chemical dependency
____ Chemotherapy
____ Cortisone treatments
____ Cough
____ Diabetes
____ Epilepsy
____ Headaches
____ Heart murmur
____ Heart problems
____ Hemophilia
____ Hepatitis
____ High blood pressure
____ HIV/AIDS
____ Jaw pain
____ Kidney disease
____ Mitral valve prolapse
____ Pacemaker
____ Pregnant
____ Radiation
____ Rheumatic fever
____ Shortness of breath
____ Sinus problems
____ Skin condition
____ Stomach problems
____ Stroke
____ Thyroid problem
____ Tobacco use
Ulcer
____ Other

MEDICATIONS

Please list medications you are currently taking:

____
____
____
____

ALLERGIES

____ Aspirin
____ Codeine
____ Dental Anesthetic
Other
____ Penicillin
____ Sulfa
____ Latex
____
____

Pharmacy name: ______________________

Pharmacy phone: ______________________

Signature: ______________________ Date: ______________________