

Patient Name _____
Patient Account No. _____

DENTAL HISTORY

Medical Alert _____

Welcome! So that we may provide you with the best possible care please complete both pages of this Medical History/Dental History form.

All information is held completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

- Hot or cold? Yes No
- Sweets? Yes No
- Biting or Chewing? Yes No
- Have you noticed any mouth odors or bad tastes? Yes No
- Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

- Have your parents experienced gum disease or tooth loss? Yes No
- Have you noticed any loose teeth or change in your bite? Yes No
- Does food tend to become caught in between your teeth? Yes No
- If yes, where? _____

Do you:

- Clench or grind your teeth while awake or asleep? Yes No
- Bite your lips or cheeks regularly? Yes No
- Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
- Mouth breathe while awake or asleep? Yes No
- Have tired jaws, especially in the morning? Yes No
- Snore or have any other sleeping disorders? Yes No
- Smoke/chew tobacco or use other tobacco products? Yes No

Have you ever had:

- Orthodontic treatment? Yes No
- Oral surgery? Yes No
- Periodontal treatment? Yes No
- Your teeth ground or the bite adjusted? Yes No
- A bite plate or mouth guard? Yes No
- A serious injury to the mouth or head? Yes No
- If so, please describe, including cause _____

Have you experienced:

- Clicking or popping of the jaw? Yes No
- Pain? (joint, ear, side of face) Yes No
- Difficulty in opening or closing the mouth? Yes No
- Difficulty in chewing on either side of the mouth? Yes No
- Headaches, neck aches or shoulder aches? Yes No
- Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

(Please complete next page)

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MEDICAL HISTORY

Medical Alert _____

- Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address City _____ State _____ Zip _____
- Have you taken any medication or drugs during the past two years?..... Yes No
- Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines? Yes No
 If yes, please list name and dosage _____
- Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimin (fenfluramine); and Redux (dexfenfluramine)? Yes No
 If yes to the above, did you have a medical exam for heart issues? Yes No
- Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
 If yes, please list: _____
- Have you been a patient in the hospital during the past five years? Yes No
- Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack) Yes No	Ulcers Yes No	Hepatitis: A B C (circle) Yes No
Chest Pain Yes No	Diabetes Yes No	Venereal Disease Yes No
Congenital Heart Disease Yes No	Thyroid Problems Yes No	A.I.D.S. Yes No
Heart Murmur Yes No	Glaucoma Yes No	H.I.V. Positive Yes No
High Blood Pressure Yes No	Contact lenses Yes No	Cold Sores/Fever Blisters Yes No
Mitral Valve Prolapse Yes No	Emphysema Yes No	Blood Transfusion Yes No
Artificial Heart Valve Yes No	Chronic Cough Yes No	Hemophilia Yes No
Heart Pacemaker Yes No	Tuberculosis Yes No	Sickle Cell Disease Yes No
Rheumatic Fever Yes No	Asthma Yes No	Bruise Easily Yes No
Arthritis/Rheumatism Yes No	Hay Fever Yes No	Liver Disease Yes No
Cortisone Medicine Yes No	Latex Sensitivity Yes No	Yellow Jaundice Yes No
Swollen Ankles Yes No	Allergies or Hives Yes No	Neurological Disorders Yes No
Stroke Yes No	Sinus Trouble Yes No	Epilepsy or Seizures Yes No
Diet (Special/Restricted) Yes No	Radiation Therapy Yes No	Fainting or Dizzy Spells Yes No
Artificial Joints (hip, knee, etc.) Yes No	Chemotherapy Yes No	Nervous/Anxious Yes No
Kidney Trouble Yes No	Tumors Yes No	Psychiatric/Psychological Care Yes No
- Do you use more than two pillows to sleep?..... Yes No
- Have you lost or gained more than 10 pounds in the past year?..... Yes No
- Do you have or have you had any disease, condition, or problem not listed?..... Yes No
 If yes, please list: _____
- Women:** Are you pregnant or think you may be pregnant?.....Yes, ____ Months No **Nursing?**..... Yes No
- Women:** Do you use birth control medications?..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature: _____ Date: _____

History Review