DENTAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

Welcome! *So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is 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 ____________________

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 taste? Yes No

Do you frequently get cold sores, blisters, or 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 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

Smoke/chew tobacco? Yes No

Have you ever had:

Orthodontic treatement? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or 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 experience:

Clicking or popping of the jaw? Yes No

Pain (joint, ear, side of face)? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches 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 yes, 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 other side)

MEDICAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

1. 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 ______
2. Have you taken any medication or drugs the past two years? .... Yes No
3. Are you taking any medication, drug or pills now? .... Yes No
   If yes, please list name and dosage ______
4. Have you ever taken prescription medications for weight loss (diet pills)? .... Yes No
   If yes, did you take any of the following:
   Yes No Fen-Phen (Fenfluramine-Phenopermine)
   Yes No Pondimen (Fenfluramine)
   Yes No Redux (Dexfenfluramine)
   If yes to any of the above, did you have a medical exam for heart issues? .... Yes No
5. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? .... Yes No
   If yes, please list: ______
6. Have you been a patient in the hospital during that past five years? .... Yes No
7. Indicate which of the following you have ad, or have at present. Circle "yes" or "no" to each item.

Heart (surgery, disease, attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	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

8. Do you use more than two pillows to sleep? .... Yes No
9. Have you lost or gained more than 10 pounds in the past year? .... Yes No
10. Do you have or have you had any disease, condition, or problem not listed? .... Yes No
    If yes, please list: ______
11. **Women** Are you: **Pregnant?** Yes, _____Months No **Nursing?** Yes No **Taking birth control pills?** 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 doctor of change in my health or medication.

Patient Signature ______ ***Date:*** ______

History Review

Dentist Signature ______ Date ______

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