

DENTAL HISTORY

Patient Name

Patient Account No.

Medical Alert

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care. 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 _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

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

Have you ever used or are you currently using topical fluoride? Yes No

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 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 yes, 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 _____

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

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

If yes, please describe _____

Patient Name _____

MEDICAL HISTORY

Patient Account No. _____

Medical Alert _____

1. Physician's Name _____ Phone () _____
 Have you had any medical care within the past two years? Yes No
 Describe _____
 2. Have you taken any medication or drugs during the past two years? Yes No
 3. Are you currently taking an medication, drugs, pills or herbal remedies, including regular dosages of aspirin? Yes No
 4. Have you ever taken prescription medications for weight loss (diet pills)? Yes No
 If yes, did you take any of the following? (Check if yes) Fen-Phen Pondimin Redux Other
 If yes to any of the above, did you have a medical exam for heart issues? Yes No
 5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? Yes No
 6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No
 If yes, please specify _____
 7. Have you been a patient in the hospital during the past five years? Yes No
 8. Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item.
- | | | |
|---|---|--|
| Heart (Surgery, Disease, Attack) <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease .. <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/Fever Blisters ... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High/Low Blood Pressure .. <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Contact Lenses <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve/
Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Cough <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease/Yellow
Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swollen Ankles. <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever/Allergy/Hives ... <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Sensitivity <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous/Anxious <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diet (Special/Restricted) ... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/Psychological
Care <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints
(Hip, Knee, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Tumors <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Hepatitis A, B, C .. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | |
9. Have you lost or gained more than 10 pounds in the last year? Yes No
 10. Do you have or have you had any disease, condition, or problem not listed? Yes No
 11. Women: Are you pregnant or think you could be pregnant? Yes ____ Months No Nursing? Yes No
 12. Do you use birth control prescriptions? Yes No

I understand the above information in 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 any change in my health or medication.

Patient / Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____