

Patient Name _____	<b>DENTAL HISTORY</b>
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 \_\_\_\_\_ 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 breath 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 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, 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 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 \_\_\_\_\_  
 \_\_\_\_\_

Patient Name \_\_\_\_\_

# MEDICAL HISTORY

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 during the past two years? ..... Yes No

3. Are you taking any medication, drugs or pills now? ..... Yes No

If yes, please list name and dosage \_\_\_\_\_

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ..... Yes No

If yes, please list: \_\_\_\_\_

5. Have you been a patient in the hospital during the past five years? ..... Yes No

6. 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 (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     |

7. Do you use more than two pillows to sleep? ..... Yes No

8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No

9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No

If yes, please list: \_\_\_\_\_

10. 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 any change in my health or medication.*

Patient /Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## History Review

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_