Patient Name

DENTAL HISTORY

Welcome! *So that we may provide you with the best possible care please complete <u>both</u> 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 Dental 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? _____

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 in 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 or chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment (braces)?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment (gum surgery)?	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
	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 other side)

Patient Name

MEDICAL HISTORY

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 in the past two years, or are you now, taking any medications, drugs or other pills? . . . . . Yes No
   If yes, please list name and dosage _____
3. Have you ever been required to pre-medicate with antibiotics for your dental appointment? . . . . . Yes No
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? . . . . . Yes No
   If yes, please list _____
5. Are you allergic to any of the following?
   ❒ Aspirin ❒ Penicillin ❒ Codeine ❒ Acrylic ❒ Metal ❒ Latex ❒ Local Anesthetics ❒ Other
6. Have you been a patient in the hospital during the past five years? . . . . . Yes No
7. Indicate which of the following you have had,or have at present. Please check the appropriate boxes below:

❒ AIDS/HIV Positive	❒ Chest Pains	❒ Genital Herpes	❒ Kidney Problems	❒ Scarlet Fever
❒ Alzheimer's Disease	❒ Cold Sores/Fever Blisters	❒ Glaucoma	❒ Leukemia	❒ Shingles
❒ Anaphylaxis	❒ Congenital Heart Disorder	❒ Hay Fever	❒ Liver Disease	❒ Sickle Cell Disease
❒ Anemia	❒ Convulsions	❒ Heart Attack/Failure	❒ Low Blood Pressure	❒ Sinus Trouble
❒ Angina	❒ Cortisone Medicine	❒ Heart Murmur*	❒ Lung Disease	❒ Spina Bifida
❒ Arthritis/Gout	❒ Diabetes	❒ Heart Pace Maker*	❒ Lupus	❒ Stomach/Intestinal Disease
❒ Artificial Heart Valve*	❒ Drug Addiction	❒ Heart Trouble/Disease*	❒ Mitral Valve Prolapse*	❒ Stroke
❒ Artificial Joint*	❒ Emphysema	❒ Hemophilia	❒ Pain in Jaw Joints	❒ Swelling of Limbs
❒ Asthma	❒ Epilepsy or Seizures	❒ Hepatitis A	❒ Parathyroid Disease	❒ Thyroid Disease
❒ Blood Disease	❒ Excessive Bleeding	❒ Hepatitis B or C	❒ Psychiatric Care	❒ Tonsillitis
❒ Blood Transfusion	❒ Excessive Thirst	❒ Herpes	❒ Radiation Treatments	❒ Tuberculosis
❒ Breathing Problem	❒ Fainting Spells/Dizziness	❒ HIgh Blood Pressure	❒ Recent Weight Loss	❒ Tumors or Growths
❒ Bruise Easily	❒ Frequent Cough	❒ HIves or Rash	❒ Renal Dialysis	❒ Ulcers
❒ Cancer	❒ Frequent Diarrhea	❒ Hypoglycemia	❒ Rheumatic Fever*	❒ Venereal Disease
❒ Chemotherapy	❒ Frequent Headaches	❒ Irregular Heartbeat	❒ Rheumatism	❒ Yellow Jaundice

   * Condition may require medication
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/Guardian Signature _____ Date _____

History Review

_____

_____

_____

_____

Dentist Signature _____ Date _____

(Please complete other side)