

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 _____ 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 you 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 cause 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

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)?

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 _____

MEDICAL HISTORY

Patient Name _____

Patient Account No. _____

Medical Alert _____

1. Have you been under the care of a medical doctor during the past 2 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	Venereal Disease.....	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	A.I.D.S.....	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problems.....	Yes	No	H.I.V. Positive.....	Yes	No
Heart Murmur.....	Yes	No	Glaucoma.....	Yes	No	Cold Sores/Fever Blisters.....	Yes	No
High Blood Pressure.....	Yes	No	Contact lenses.....	Yes	No	Blood Transfusion.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Emphysema.....	Yes	No	Hemophilia.....	Yes	No
Artificial Heart Valve.....	Yes	No	Chronic Cough.....	Yes	No	Sickle Cell Disease.....	Yes	No
Heart Pacemaker.....	Yes	No	Tuberculosis.....	Yes	No	Bruise Easily.....	Yes	No
Rheumatic Fever.....	Yes	No	Asthma.....	Yes	No	Liver Disease.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Hay Fever.....	Yes	No	Yellow Jaundice.....	Yes	No
Cortisone Medicine.....	Yes	No	Latex Sensitivity.....	Yes	No	Neurological Disorders.....	Yes	No
Swollen Ankles.....	Yes	No	Sinus Trouble.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Stroke.....	Yes	No	Radiation Therapy.....	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Diet (Special/Restricted).....	Yes	No	Chemotherapy.....	Yes	No	Nervous/Anxious.....	Yes	No
Artificial Joints (hip, knee, etc.).....	Yes	No	Tumors.....	Yes	No	Psychiatric/Psychological Care.....	Yes	No
Kidney Trouble.....	Yes	No	Hepatitis A (infectious) B (serum)...	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

Dentist Signature _____ Date _____