DENTAL HISTORY

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.

Patient Name: _____ Medical Alert: _____

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 _____Phone # _____
Address _____State _____Zip_____
How often do you have dental exams? _____ Brush your teeth? _____ Use floss? _____
What other dental aids do you use? (Interplak, toothpick. etc.) _____
Do you have any 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, 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? _____

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

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

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)

MEDICAL HISTORY

Patient Name:_____ 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, including regular dosages of aspirin?…….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-Phentermine)
   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 the past five years?…… Yes No**

7. **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 of 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/Guardian Signature_____Date_____