

<b>Patient Name</b>
<b>Patient Account No.</b>

# DENTAL HISTORY

<b>Medical Alert</b>
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*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 Month 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? \_\_\_\_\_

Have you ever used or are 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 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 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 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 \_\_\_\_\_

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 \_\_\_\_\_

# MEDICAL HISTORY

<b>Patient Name:</b>	<b>Medical Alert:</b>
<b>Patient Account No.:</b>	

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 taking any medication, drugs, pills or herbal remedies now, 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:    Fen-Phen    Pondimen    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 less prevention drugs such as Fosamax, Actone, Boniva or other similar drugs?..... Yes No

6. Have you been a patient in the hospital drugs 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 of them:

- |  |     |    |                              |     |    |                                   |     |    |
|--|-----|----|------------------------------|-----|----|-----------------------------------|-----|----|
| 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/H.I.V. Positive.....      | Yes | No |
| Heart Murmur.....                        | Yes | No | Glaucoma.....                | Yes | No | Cold Sores/Fever Blisters.....    | Yes | No |
| High/Low 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/Pacemaker.....    | Yes | No | Chronic Cough.....           | Yes | No | Sickle Cell Disease.....          | Yes | No |
| Rheumatic Fever.....                     | Yes | No | Tuberculosis.....            | Yes | No | Bruise Easily.....                | Yes | No |
| Arthritis/Rheumatism.....                | Yes | No | Asthma.....                  | Yes | No | Liver Disease/Yellow Jaundice..   | Yes | No |
| Cortisone Medicine.....                  | Yes | No | Hay Fever/Allergy/Hives..... | Yes | No | Neurological Disorders.....       | Yes | No |
| Swollen Ankles.....                      | Yes | No | Latex Sensitivity.....       | Yes | No | Epilepsy or Seizures.....         | Yes | No |
| Stroke.....                              | Yes | No | Sinus Trouble.....           | Yes | No | Fainting or Dizzy Spells.....     | Yes | No |
| Diet (Special/Restricated).....          | Yes | No | Radiation Therapy.....       | Yes | No | Nervous/Anxious.....              | Yes | No |
| Artificial Joints (hip, knee, etc.)..... | Yes | No | Chemotherapy.....            | Yes | No | Psychiatric/Psychological Care... | Yes | No |
| Kidney Trouble.....                      | Yes | No | Tumors.....                  | Yes | No |                                   |     |    |

8. Do you have any sleeping or snoring issues?..... 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

11. Women: Are you pregnant or think you could be pregnant?..... Yes No

If yes, how many months? \_\_\_\_\_

Are you nursing? Yes No

12. Do you use birth control prescriptions?..... Yes No