DENTAL HISTORY

Welcome! *So that we may provide you with the best possible care,*
Please complete the medical/dental history form.
All information is completely confidential.

Date_________________

Patient Name____

What is the reason for your visit?____

Date of Last Dental Visit ___________________Last Dental Cleaning ________________Last Full X-rays _______________
What was done on your last dental visit?____

Previous Dentists' name____

Address____

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? (Sonicare, 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 Yes No
If yes, where?
or change in your bite? Yes No
Does food tend to become caught in between your teeth? Yes No

Do you:

Clench/grind teeth while awake/asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth? Yes No
(pencils, pipe, pins, nail, fingernails) Yes No
Mouth breath while awake or asleep? Yes No
Have tired jaws, especially in the am? 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 in the jaw? Yes No
Pain? (joint, ear, side of face)
Difficulty in opening/closing the mouth? Yes No
Difficulty in chewing on either side? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscle (neck or 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?
If so, what is your biggest concern?______________

____
Have you ever had an upsetting dental experience?
If yes, please describe:_________________________
____

Is there anything else about having dental treatment that you would like us to know?____________________________

____

MEDICAL HISTORY

Patient Name____

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
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" to each item.

Heart (Surgery, Disease, Attack) …Yes
Chest Pain…………………………..Yes
Congenital Heart Disease………….Yes
Heart Murmur………………………..Yes
High Blood Pressure………………..Yes
Mitral Valve Prolapse……………….Yes
Artificial Heart Valve………………..Yes
Heart Pacemaker……………………Yes
Rheumatic Fever……………………Yes
Arthritis/Rheumatism……………… Yes
Cortisone Medicine…………………Yes
Swollen Ankles………………………Yes
Stroke…………………………………Yes
Diet (Special Restricted)……………Yes
Artificial Joints (hip, knee, etc)………Yes
Kidney Trouble………………………Yes

Ulcers………………………Yes
Diabetes……………………Yes
Thyroid Problems…………Yes
Glaucoma…………………Yes
Contact Lenses……………Yes
Emphysema………………..Yes
Chronic Cough……………..Yes
Tuberculosis………………..Yes
Asthma…………………….. Yes
Hay Fever…………………..Yes
Latex Sensitivity……………Yes
Allergies or Hives…………..Yes
Sinus Trouble………………Yes
Radiation Therapy………….Yes
Chemotherapy………………Yes
Tumors………………………Yes

Hepatitis A (infectious) B (serum)……..Yes
Veneral Disease…………………………..Yes
A.I.D.S……………………………………..Yes
H.I.V. Positive……………………………..Yes
Cold Sores/Fever Blisters………………..Yes
Blood Transfusion…………………………Yes
Hemophilia…………………………………Yes
Sickle Cell Disease………………………..Yes
Bruise Easily………………………………Yes
Liver Disease………………………………Yes
Yellow Jaundice……………………………Yes
Neurological Disorders……………………Yes
Epilepsy or Seizures………………………Yes
Fainting or Dizzy Spells………………… Yes
Nervous/Anxious………………………… Yes
Psychiatric/Psychological Care……………Yes

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 my questions to the best of my knowledge. Should further information be needed, you will have my permission to ask the respective health care provider or agency, which may release such information to you. **I will notify the doctor of any change in my health or medication.**

Patient (or Patient's Guardian) Signature____Date_______________

History Review

Dentist Signature____Date_______________