DENTAL HISTORY

PATIENT NAME	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** _____

Previous Dentist's name _____

Address _____ State _____ Zip _____ Phone _____

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? ☐ Y ☐ N

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	☐ Y	☐ N
Sweets?	☐ Y	☐ N
Biting or Chewing?	☐ Y	☐ N
Have you noticed any mouth odors or bad tastes?	☐ Y	☐ N
Do you frequently get cold sores, blisters?	☐ Y	☐ N
Any other oral lesions?	☐ Y	☐ N

Do your gums bleed or hurt?	☐ Y	☐ N
Have your parents experienced gum disease or tooth loss?	☐ Y	☐ N
Have you noticed any loose teeth or change in your bite?	☐ Y	☐ N
Does food tend to become caught in between your teeth?	☐ Y	☐ N

Do you:

Clench or grind your teeth while awake or asleep?	☐ Y	☐ N
Bite your lips or cheeks regularly?	☐ Y	☐ N
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	☐ Y	☐ N
Mouth breath while awake or asleep?	☐ Y	☐ N
Have tired jaws, especially in the morning?	☐ Y	☐ N
Smoke/chew tobacco	☐ Y	☐ N

Have you ever had:

Orthodontic treatment?	☐ Y	☐ N
Oral surgery?	☐ Y	☐ N
Periodontal treatment?	☐ Y	☐ N
Your teeth ground or the bite adjusted?	☐ Y	☐ N
A bite plate or mouth guard?	☐ Y	☐ N
A serious injury to the mouth or head?	☐ Y	☐ N

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	☐ Y	☐ N
Pain (joint, ear, side of face)?	☐ Y	☐ N
Difficulty in opening or closing you mouth?	☐ Y	☐ N
Difficulty in chewing on either side of the mouth?	☐ Y	☐ N
Headaches, neckaches or shoulder aches?	☐ Y	☐ N
Sore muscles (neck, shoulders)?	☐ Y	☐ N

Are you satisfied with your teeth's appearance?	☐ Y	☐ N
Would you like to keep all of your teeth all of your life?	☐ Y	☐ N
Do you feel nervous about dental treatment?	☐ Y	☐ N

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience?	☐ Y	☐ N

If yes, please describe: _____

_____

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

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/or had recent surgery (cosmetic surgery)? ☐ Y ☐ N
   If yes, for what? _____
   Physician's name _____ Phone _____
   Address _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ☐ Y ☐ N
3. Are you taking any medication, drugs or pills now? ☐ Y ☐ N
   If yes, please list name and dosage _____
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ☐ Y ☐ N
   If yes, please list: _____
5. Have you been a patient in the hospital during the last five years? ☐ Y ☐ N
6. Indicate which of the following you have had, or have at present.

Heart (Surgery, Disease, Attack)	☐ Y ☐ N	Ulcers	☐ Y ☐ N	Hepatitis A (infectious) B (serum)	☐ Y ☐ N
Chest Pain	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Hepatitis C	☐ Y ☐ N
Congenital Heart Disease	☐ Y ☐ N	Thyroid Problems	☐ Y ☐ N	Venereal Disease	☐ Y ☐ N
Heart Murmur	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	A.I.D.S.	☐ Y ☐ N
High Blood Pressure	☐ Y ☐ N	Contact Lenses	☐ Y ☐ N	H.I.V. Positive	☐ Y ☐ N
Mitral Valve Prolapse	☐ Y ☐ N	Emphysema	☐ Y ☐ N	Cold Sores/Fever Blisters	☐ Y ☐ N
Artificial Heart Valve	☐ Y ☐ N	Chronic Cough	☐ Y ☐ N	Blood Transfusion	☐ Y ☐ N
Heart Pacemaker	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N	Hemophilia	☐ Y ☐ N
Rheumatic Fever	☐ Y ☐ N	Asthma	☐ Y ☐ N	Sickle Cell Disease	☐ Y ☐ N
Arthritis/Rheumatism	☐ Y ☐ N	Hay Fever	☐ Y ☐ N	Bruise Easily	☐ Y ☐ N
Cortisone Medicine	☐ Y ☐ N	Latex Sensitivity	☐ Y ☐ N	Liver Disease	☐ Y ☐ N
Swollen Ankles	☐ Y ☐ N	Allergies or Hives	☐ Y ☐ N	Yellow Jaundice	☐ Y ☐ N
Stroke	☐ Y ☐ N	Sinus Trouble	☐ Y ☐ N	Neurological Disorders	☐ Y ☐ N
Diet (Special/Restricted)	☐ Y ☐ N	Radiation Therapy	☐ Y ☐ N	Epilepsy or Seizures	☐ Y ☐ N
Artificial Joints (hip, knee, etc.)	☐ Y ☐ N	Chemotherapy	☐ Y ☐ N	Fainting or Dizzy Spells	☐ Y ☐ N
Kidney Trouble	☐ Y ☐ N	Tumors	☐ Y ☐ N	Nervous/Anxious	☐ Y ☐ N
High Cholesterol	☐ Y ☐ N	Smoke Cigarettes/Chew Tobacco	☐ Y ☐ N	Psychiatric/Psychological Care	☐ Y ☐ N

7. Have you ever been asked to use pre-medication/antibiotics prior to a dental treatment? ☐ Y ☐ N
   If yes, please describe _____
8. Do you use more than two pillows to sleep? ☐ Y ☐ N
9. Have you lost or gained more than 10 pounds in the last year? ☐ Y ☐ N
10. Do you have or have you had any disease, condition, or problem not listed here? ☐ Y ☐ N
    If yes, please list: _____
11. **Women.** Are you: **Pregnant?** ☐ Y ____ Months ☐ N **Taking birth control pills?** ☐ Y ☐ N
    Nursing? ☐ Y ☐ N If yes, please describe _____

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

Doctor Signature _____ **Date** _____