Patient Name

Patient Account No.

DENTAL HISTORY

Medical Alert

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.
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 _____ Telephone _____

Address _____ State _____ Zip _____

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 you 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 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 taste?	☐ 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 yes, 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, neck aches 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 _____

PLEASE COMPLETE OTHER SIDE

Patient Name

Patient Account No.

MEDICAL HISTORY

Medical Alert

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 currently taking an medication, drugs, pills or herbal remedies, 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? (Check if yes) ☐ 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 loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ☐ Yes ☐ No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ☐ Yes ☐ No
   If yes, please specify _____
7. Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No
8. Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No	AIDS/HIV Positive	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Contact Lenses	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Artificial Heart Valve/ Pacemaker	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Chronic Cough	☐ Yes	☐ No	Liver Disease/Yellow Jaundice	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No	Hay Fever/Allergy/Hives	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Latex Sensitivity	☐ Yes	☐ No	Nervous/Anxious	☐ Yes	☐ No
Diet (Special/Restricted)	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Artificial Joints (Hip, Knee, etc.)	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No			
			Chemotherapy	☐ Yes	☐ No			
			Tumors	☐ Yes	☐ No			
			Hepatitus A, B, C	☐ A	☐ B ☐ C			

9. Have you lost or gained more than 10 pounds in the last 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 ____ Months ☐ No Nursing? ☐ Yes ☐ No
12. Do you use birth control prescriptions? ☐ Yes ☐ No

I understand the above information in 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 _____