

|                           |
|---------------------------|
| Patient Name _____        |
| Patient Account No. _____ |

# DENTAL HISTORY

|                     |
|---------------------|
| 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 \_\_\_\_\_

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? \_\_\_\_\_

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 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 \_\_\_\_\_

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 \_\_\_\_\_  
 Patient Account No. \_\_\_\_\_

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 or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines?..... Yes No  
 If yes, please list name and dosage \_\_\_\_\_
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimin (fenfluramine); and Redux (dexfenfluramine)?..... Yes No  
 If yes to 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 B C (circle) ...        | 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 or 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 or think you may be pregnant? Yes, \_\_\_ Months No **Nursing?** Yes No
12. **Women:** Do you use birth control medications?..... 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 dentist of any changes in my health or medication.*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## History Review

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_