Patient Name

MEDICAL HISTORY

1. Physician's Name: _____ Phone _____
2. Are you currently taking any medication, drugs, pills or herbal remedies, including regular doses of aspirin? Yes No
   If yes, please list name and dosage: _____
3. 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
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? Yes No
5. Are you aware of having an allergic (**or adverse)** reaction to any substance or medication? Yes No
   If yes, please specify: _____
6. Have you had any medical care or been hospitalized within the past two years? Yes No
   If yes, please describe: _____

7. Indicate which of the following you have had, or have at the present. Circle "Yes" or "No" to each item.

Heart Disease	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle)	Yes	No
Heart Murmur, Attack, Surgery	Yes	No	Diet (special/restricted)	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Diabetes	Yes	No	AIDS/HIV Positive	Yes	No
Chest Pain	Yes	No	Thyroid Problems	Yes	No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Glaucoma	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Contact Lenses	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve	Yes	No	Emphysema	Yes	No	Blood Disease	Yes	No
Pacemaker	Yes	No	Asthma/Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Liver Disease/Yellow Jaundice	Yes	No
Cortisone Medicine	Yes	No	Allergy to metal, acrylic, sutures	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/Restricted)	Yes	No	Tumors	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee,…)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care	Yes	No
Kidney Trouble	Yes	No	Radiation Therapy	Yes	No			

8. Do you have or have you had any disease, condition, or problem not listed? Yes No
   If so, please list: _____
9. **Women:** Are you pregnant or think you could be pregnant? Yes _____Months No **Nursing?** Yes No
10. Do you use birth control prescriptions? 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 doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____
Comments:

Dentist Signature_____ Date _____

DENTAL HISTORY

Patient Name:_____

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: Have you ever had:

Hot or cold?	Yes	No	Orthodontic treatment?	Yes	No
Sweets?	Yes	No	Oral surgery?	Yes	No
Biting or Chewing?	Yes	No	Periodontal treatment?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No	Your teeth ground or the bite adjusted?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No	A bite plate or mouth guard?	Yes	No
			A serious injury to the mouth or head?	Yes	No
			It so, please describe, including cause_____		
Do your gums bleed or hurt?	Yes	No	_____		
Have your parents experienced gum disease or tooth loss?	Yes	No	**Have you experienced:**		
Have you noticed any loose teeth or change in your bite?	Yes	No	Clicking or popping of the jaw?	Yes	No
			Pain? (joint, ear, side of face)	Yes	No
Does food tend to become caught in between your teeth?	Yes	No	Difficulty in opening or closing the mouth?	Yes	No
			Difficulty in chewing on either side of the mouth?	Yes	No
If yes, where?_____			Headaches, neckaches or shoulder aches?	Yes	No
			Sore muscles (neck, shoulders)?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No	**Are you satisfied with your teeth's appearance?**	Yes	No
Bite your lips or cheeks regularly?	Yes	No	Would you like to keep all of your teeth all of your life?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No	Do you feel nervous about having dental treatment?	Yes	No
Mouth breathe while awake or asleep?	Yes	No	If so, what is your biggest concern?		
Have tired jaws, especially in the morning?	Yes	No	_____		
Smoke/chew tobacco?	Yes	No	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 _____
_____
_____