

# MEDICAL HISTORY

Patient Name \_\_\_\_\_

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

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 taking any medication, drugs, pills or herbal remedies now, including regular dosages of aspirin? ..... Yes    No  
 If yes, please list name and dosage \_\_\_\_\_
4. Have you ever taken prescription medications for weight loss (diet pills)? ..... Yes    No  
 If yes, did you take any of the following: (circle if yes)            Fen-Phen            Pondimin            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, Actone, Boniva or other similar drugs? ..... Yes    No
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 (infectious) B (serum)....	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./H.I.V. Positive .....	Yes	No
Heart Murmur .....	Yes	No	Glaucoma .....	Yes	No	Cold Sores/Fever Blisters .....	Yes	No
High/Low Blood Pressure.....	Yes	No	Contact lenses .....	Yes	No	Blood Transfusion .....	Yes	No
Mitral Valve Prolapse .....	Yes	No	Emphysema .....	Yes	No	Hemophilia .....	Yes	No
Artificial Heart Valve/Pacemaker.....	Yes	No	Chronic Cough .....	Yes	No	Sickle Cell Disease .....	Yes	No
Rheumatic Fever .....	Yes	No	Tuberculosis .....	Yes	No	Bruise Easily .....	Yes	No
Arthritis/Rheumatism .....	Yes	No	Asthma .....	Yes	No	Liver Disease/Yellow Jaundice ....	Yes	No
Cortisone Medicine .....	Yes	No	Hay Fever/Allergy/Hives.....	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	Radiation Therapy .....	Yes	No	Nervous/Anxious .....	Yes	No
Artificial Joints (hip, knee, etc.) .....	Yes	No	Chemotherapy .....	Yes	No	Psychiatric/Psychological Care .....	Yes	No
Kidney Trouble .....	Yes	No	Tumors .....	Yes	No			

8. Do you have any sleeping or snoring issues? ..... 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 could be pregnant?    Yes    \_\_\_\_\_ Months    No            **Nursing?**    Yes    No
12. 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 change in my health or medication.*

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

**History Review**

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

# DENTAL HISTORY

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

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)