



Patient Name		Today's Date	
Patient Account No.		Medical Alert	

Yes No

- 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 \_\_\_\_\_
- Have you taken any medication or drugs during the past two years?  Yes  No
- Are you taking any medication, drugs or pills now, including regular dosages of aspirin?  Yes  No  
 If yes, please list name and dosage: \_\_\_\_\_
- Have you ever taken prescription medications for weight loss (diet pills)?  Yes  No  
 If yes, did you take any of the following: Fen-Phen (Fenfluramine-Phentermine) \_\_\_\_\_  Yes  No  
 Pondimin (Fenfluramine) \_\_\_\_\_  Yes  No  
 Redux (Dexfenfluramine) \_\_\_\_\_  Yes  No  
 If yes to any of the above, did you have a medical exam for heart issues? \_\_\_\_\_  Yes  No
- Are you aware of having an allergic (or adverse) reaction to any medication or substance?  Yes  No  
 If yes, please list: \_\_\_\_\_
- Have you been a patient in the hospital during the past five years?  Yes  No
- Indicate which of the following you have had, or have at present. Check "yes" or "no".

	Yes	No		Yes	No		Yes	No
Heart (Surgery, Disease, Attack)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (infectious) B (serum)	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	A.I.D.S	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	H.I.V. Positive	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diet (Special/Restricted)	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints (hip, knee, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/Anxious	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/Psychological Care	<input type="checkbox"/>	<input type="checkbox"/>

- Do you use more than two pillows to sleep?  Yes  No
- Have you lost or gained more than 10 pounds in the past year?  Yes  No
- Do you have or have you had any disease, condition, or problem not listed?  Yes  No  
 If yes, please list: \_\_\_\_\_
- Are you pregnant?  Yes, \_\_\_ Months  No | Nursing?  Yes  No | Taking birth control pills?  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 \_\_\_\_\_



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*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.*

1. What is the reason for your visit today? \_\_\_\_\_

2. What was done at your last dental visit? \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Last dental cleaning \_\_\_\_\_ Last x-rays \_\_\_\_\_  
 Previous dentist's name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

3. 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.) \_\_\_\_\_

4. Do you have any dental problems now? .....  Yes  No

If yes, please describe: \_\_\_\_\_

Check "yes" or "no".	Yes	No		Yes	No
<b>Are any of your teeth sensitive to:</b>			<b>Have you experienced:</b>		
Hot or cold?	<input type="checkbox"/>	<input type="checkbox"/>	Clicking or popping of the jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Sweets?	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in opening or closing the mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Biting or Chewing?	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in chewing on either side of the mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any mouth odors or bad tastes?	<input type="checkbox"/>	<input type="checkbox"/>	Pain? (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently get cold sores, blisters or any other oral lesions?	<input type="checkbox"/>	<input type="checkbox"/>	Headaches, neckaches or shoulder aches?	<input type="checkbox"/>	<input type="checkbox"/>
			Sore muscles (neck, shoulders)?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Do your gums bleed or hurt?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Have you ever had:</b>		
Have your parents experienced gum disease or tooth loss?	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any loose teeth or change in your bite?	<input type="checkbox"/>	<input type="checkbox"/>	Oral Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Does food tend to become caught in between your teeth? If yes, where?	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment?	<input type="checkbox"/>	<input type="checkbox"/>
			Your teeth ground or the bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Do you:</b>			A bite plate or mouth guard?	<input type="checkbox"/>	<input type="checkbox"/>
Hold foreign objects with your teeth? (pencils, pipes, pins, nails, fingernails)	<input type="checkbox"/>	<input type="checkbox"/>	A serious injury to the mouth or head? If so, please describe, including cause:	<input type="checkbox"/>	<input type="checkbox"/>
Clench or grind your teeth while awake or asleep?	<input type="checkbox"/>	<input type="checkbox"/>			
Bite your lips or cheeks regularly?	<input type="checkbox"/>	<input type="checkbox"/>			
Mouth breathe while awake or asleep?	<input type="checkbox"/>	<input type="checkbox"/>			
Have tired jaws, especially in the morning?	<input type="checkbox"/>	<input type="checkbox"/>			
Smoke/chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>			

5. Are you satisfied with your teeths appearance? .....  Yes  No

6. Would you like to keep all of your teeth all of your life? .....  Yes  No

7. Do you feel nervous about having dental treatment? .....  Yes  No

If so, what is your biggest concern? \_\_\_\_\_

8. Have you ever had an upsetting dental experience? .....  Yes  No

If yes, please describe: \_\_\_\_\_

9. Is there anything else about having dental treatment that you would like us to know? .....  Yes  No

If yes, please describe: \_\_\_\_\_