

Arthur J. Natvig, D.D.S

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Patient Name	MEDICAL HISTORY
Patient Chart No.	

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, drugs or pills now ----- Yes No
If yes, please list name and dosage _____
Are you aware of having an allergic (or adverse reaction) to any medication or substance ----- Yes No
If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ----- Yes No
6. 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 ----- 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 Busters ----- 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 Des ease ----- 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 (tip, knee, etc.) ----- Yes No | Chemotherapy ----- Yes No | Nervous/Anxious ----- Yes No |
| Kidney Trouble ----- Yes No | Tumors ----- Yes No | Psychiatric/Psychological Care ----- Yes No |
7. Do you use more than two pillows to sleep? ----- Yes No
8. Have you lost or gained more than 10-pounds in the past year ----- Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ----- Yes No
If yes, please list: _____
10. **Women.** 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 any change in my health or medication.

Patient Guardian Signature _____ Date _____

History Review

Doctor Signature _____ Date _____

Patient Name	DENTAL HISTORY	
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

Do you:

Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Oral surgery? Yes No
Periodontal treatment? Yes No

Pain? (joint, ear, side of face) Yes No

Have you ever had:

A bite plate or mouth guard? Yes No
Your teeth ground or the bite adjusted? 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?

Have you experienced:

Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth appearance?

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

Hold Foreign objects with your teeth? Yes No
(pencils, pipe, pins, nails, fingernails) Orthodontic treatment?

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 _____

Clicking or popping of the jaw? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe _____

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