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 _____Telephone_____

Address _____ State_____ Zip_____

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, waterpik, 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 bad tastes or mouth odors? ..... Yes No

Do you frequently get cold sores, blisters or other lesions? .. Yes No

Do your gums bleed or hurt? ..... Yes No

Have you noticed any loose teeth or changes in your bite? .. Yes No

Does food get 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

Mouth breathe while asleep or awake? ..... Yes No

Snore or have any other sleeping disorder? ..... Yes No

Smoke/chew/use tobacco products? ..... Yes No

Feel nervous about receiving dental treatment? ..... Yes No

Hold objects with your teeth? (Pencils, pipe, bobby pins, etc.)

Yes No

Have you ever had:

Orthodontic treatment?..... Yes No

Oral Surgery?..... Yes No

Periodontal treatment?..... Yes No

Bite splint or mouth guard?..... Yes No

A serious injury to the mouth or head?..... Yes No

If yes, 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 chewing on either side of the mouth? ..... Yes No

Headaches, neck aches, or shoulder aches?..... Yes No

Sore muscles? (Neck, shoulders, jaw)?..... Yes No

Are you satisfied with the appearance of your teeth?..... Yes No

Would you like to replace your silver fillings?..... Yes No

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

Have you ever been told you need to take pre-medication prior to dental treatment? _____

Is there anything else about your dental health/treatment you would like us to know? _____

(Please complete reverse side)

Medical History

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

   If yes, please list name and dosage_____

3. Are you currently taking any medication, drugs, pills, herbal remedies, including regular dosage of aspirin?..... Yes No

   If yes, please list name and dosage_____

4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other bisphosphonates?..... 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 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./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	Cancer.....	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

10. Women: Are you pregnant or think you could be pregnant? Yes _____Months No Nursing Yes No

11. 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_____

Dentist Signature_____ Date_____