Medical History

Name ______________________________ Date of Birth ______________

Please fill out the form to the best of your ability. Health problems that you may have, or medications that you may be taking have an impact on the dental care you receive. Thank you.

Primary Care Physician's Name ______________________________ Phone No. ______________

Primary Care Physician's Address ______________________________

List any prior **hospitalizations** or **surgeries** including the year and reason:

____

____

Have you ever had a serious head or neck injury? If yes, explain: ______________________________

Please list any **medications** you are currently taking, including dosage and frequency: Pharmacy # ______________

____

____

Do you take, or have you taken Phen-Fen, Redux, Bonivia, Fosamax, Actonel, Didronel, Shelid, Aredia, Zometa? (Please circle)

Do you use **tobacco**? If yes, how much and how often? ______________ Smoke or Smokeless (Please circle)

Do you use **controlled substances**? If yes, what, how much and how frequently? ______________________________

Have you ever had **prolonged** or **unusual bleeding**? If yes, explain: ______________________________

Women Only: Are you: ___ pregnant/trying to get pregnant? ___ Nursing? ___Taking Oral Contraceptives?

Are you **allergic** to any of the following? ___ Aspirin ___ Penicillin ___ Codeine ___ Acrylic ___ Metal ___ Latex ___ Local Anesthetics

___ Other: ______________ Please explain the reaction: ______________________________

Do you have, or have you had, any of the following?

___ AIDS/HIV Positive
___ Alzheimer's disease
___ Anaphylaxis
___ Anemia
___ Angina
___ Arthritis/Gout
___ Artificial Heart Valve
___ Artificial Joint
___ Asthma
___ Blood Disease
___ Blood Transfusion
___ Bruise Easily
___ Cancer
___ Chemotherapy
___ Chest Pains
___ Cold Sores/Fever Blisters
___ Congenital Heart Disorder
___ Convulsions
___Cortisone Medicine
___ Diabetes
___ Drug Addiction
___ Easily Winded
___ Emphysema
___ Epilepsy or Seizures
___ Excessive Bleeding
___ Excessive Thirst
___ Fainting Spells/Dizziness
___ Frequent Cough
___ Frequent Headaches
___ Glaucoma
___ Hay Fever
___ Heart Attack/Failure
___ Heart Murmur
___ Heart Pacemaker
___ Heart Disease
___ Hemophilia
___ Hepatitis A
___ Hepatitis B or C
___ Herpes
___ High Blood Pressure
___ Hives or Rash
___ Hypoglycemia
___ Irregular Heartbeat
___ Kidney Problems
___ Leukemia
___ Liver Disease
___ Low Blood Pressure
___ Lung Disease
___ Mitral Valve Prolapse
___ Pain in Jaw Joints
___ Parathyroid Disease
___ Psychiatric Care
___ Radiation Treatments
___ Recent Weight Loss
___ Renal Dialysis
___ Rheumatic Fever
___ Rheumatism
___ Scarlet Fever
___ Shingles
___ Sickle Cell Disease
___ Sinus Trouble
___ Stomach Intestinal
___ Stroke
___ Swelling of Limbs
___ Thyroid Disease
___ Tonsillitis
___ Tuberculosis
___ Tumors
___ Ulcers
___ Venereal Disease
___ Yellow Jaundice

Have you ever had a **serious illness** not listed above? If **yes**, please explain: ______________________________

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 ______________

Print Name ______________________________

Dental History

Name:________________________________ Reason for today's visit:____

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 Code ____________________ Telephone No. ___________________________________

How often do you brush your teeth? _______________________ How often do you floss your teeth? ______________________

What other dental aids do you use? (Toothpick, softpick, etc.) ____

Do you have any dental problems now (please circle)? Yes No

If yes, please describe: ____

Are any of your teeth sensitive to:

___ Hot or cold?
___ Sweets?
___ Biting or chewing?
___ Have you noticed any mouth odors or bad tastes?
___ Do you frequently get cold sores, blisters, or any other oral lesions?

___ Do your gums bleed or hurt?
___ Have your parents experienced gum disease or tooth loss?
___ Have you noticed any loose teeth or change in your bite?
___ Does food tend to become caught in between your teeth?
If yes, where: ____________________

Do you:

___ Clench or grind your teeth while awake or asleep?
___ Bite your lips or cheeks regularly?
___ Hold foreign objects with your teeth?
___ Mouth breathe while awake or asleep?
___ Have tired jaws, especially in the morning?

Have you ever had:

___ Orthodontic treatment?
___ Oral surgery?
___ Periodontal treatment?

Have you ever had:

___ Your teeth ground or bite adjusted?
___ A bite plate or mouth guard?
___ A serious injury to the mouth or head?
If yes, please describe: _______________
____

Have you experienced:

___ Clicking or popping of the jaw?
___ Pain (joint, ear, side of face)?
___ Difficulty in opening or closing the mouth?
___ Difficulty in chewing on either side of the mouth?
___ Headaches, neck aches, or shoulder aches?
___ Sore muscles (neck, shoulders)?

Please circle Yes or No with the following:

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?

____

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