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?____________

Have you ever used or are currently using topical fluoride? Yes No

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 hurt or bleed? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or a 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? Yes No
(pencils, pipe, pins, nails, fingernails)

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

Headaches, neck aches 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:

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

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)

Patient Name	**MEDICAL HISTORY**
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 currently taking any medication, drugs, pills or herbal remedies, 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
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? …. Yes No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ………… Yes No
   If so, please specify ______________________
7. Have you been a patient in the hospital during the past five years?............ Yes No
8. 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 ………	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		Yes	No

9. Have you lost or gained more than 10 pounds in the past year? ______________________
10. Do you have or have you had any disease, condition or problem not listed? ______________________
    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 any change in my health or medication.

Patient / Guardian Signature ______________________ Date ______________________

History Review

Dentist Signature ______________________ Date ______________________