Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

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 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? (pencils, pipe, pins, nails, fingernails) ..... Yes No

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

Have tired jaws, especially in the morning? ..... Yes No

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

Snore, have trouble waking in the morning, or feel sleepy during the day? ..... 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 chewing on either side of the mouth? ..... Yes No

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

Sore muscles (neck, shoulders)? ..... Yes No

Are you happy with you 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 you biggest concern?

_____

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

If so, please describe:

_____

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	
Patient Account No.	Medical Alert

MEDICAL HISTORY

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, drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now, including regular doses of aspirin? ..... Yes No
   If yes, please list name and dosage _____
4. 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
Congenial 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 Blisters	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	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivities	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Troubles	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (Hip, 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 have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
8. **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 change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____