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 the medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Last Dental Visit_____ **Last Dental Cleaning**_____ **Last Full Mouth X-ray** _____

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? _____

Have you ever used or are currently using topical fluoride?

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? Y / N
Sweets? Y / N
Biting or Chewing? Y / N
Have you noticed any mouth odors or bad tastes? Y / N
Do you frequently get cold sores, blisters or any other oral lesions? Y / N
Do your gums bleed or hurt? Y / N
Have your parents experienced gum disease or tooth loss? Y / N
Have you noticed any loose teeth or change in your bite? Y / N
Does food tend to become caught in between your teeth? Y / N
If yes, where?_____

Do you:

Clench or grind your teeth while awake or asleep? Y / N
Bite your lips or cheeks regularly? Y / N
Hold foreign objects with your teeth? (pencils, pipe, etc.) Y / N
Mouth breathe while awake or asleep? Y / N
Have tired jaws, especially in the morning? Y / N
Snore or have any other sleeping disorders? Y / N
Smoke/chew tobacco or use other tobacco products? Y / N

Have you ever had:

Orthodontic treatment? Y / N
Oral Surgery? Y / N
Periodontal treatment? Y / N
Your teeth ground or the bite adjusted? Y / N
A bite plate or mouth guard? Y / N
A serious injury to the mouth or head? Y / N
Please describe, including cause: _____

Have you experienced:

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

Are you satisfied with your teeth's appearance? Y/ N

Would you like to replace your silver fillings? Y / N
Would you like to keep all of your teeth all of your life? Y / N

Do you feel nervous about having dental treatment? Y / N

Please describe _____

Have you ever had an upsetting dental experience? Y / N

Please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? Y / N

Is there anything else about having dental treatment that you would like us to know? Y / N

Please describe _____

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? ..... Y / N

   Describe _____

2. Have you taken any medication or drugs during the past two years? ..... Y / N

   If yes, please list name and dosage _____

3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Y / N

   If yes, please list name and dosage _____

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

   If yes, please list name and dosage _____

5. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ..... Y / N

   If yes, please list name and dosage _____

6. Have you been a patient in the hospital during the past five years? ..... Y / N

7. Indicate which of the following you have had or have at present. Check "yes" or "no" to each item.

Heart (Surgery, Disease, Attack) ...	Y / N	Ulcers ...	Y / N	Hepatitis (A, B, C) ...	Y / N
Chest Pain ...	Y / N	Diabetes ...	Y / N	Venereal Disease ...	Y / N
Congenital Heart Disease ...	Y / N	Thyroid Problems ...	Y / N	A.I.D.S./H.I.V Positive ...	Y / N
Heart Murmur	Y / N	Glaucoma ...	Y / N	Cold Sores/Fever Blisters ...	Y / N
High/Low Blood Pressure ...	Y / N	Contact lenses ...	Y / N	Blood Transfusion ...	Y / N
Mitral Valve Prolapse ...	Y / N	Emphysema ...	Y / N	Hemophilia ...	Y / N
Artificial Heart Valve/Pacemaker ...	Y / N	Chronic Cough ...	Y / N	Sickle Cell Disease ...	Y / N
Rheumatic Fever ...	Y / N	Tuberculosis ...	Y / N	Bruise Easily ...	Y / N
Arthritis/Rheumatism ...	Y / N	Asthma ...	Y / N	Liver Disease/Yellow Jaundice	Y / N
Cortisone Medicine ...	Y / N	Hay Fever/Allergy/Hives ...	Y / N	Neurological Disorders ...	Y / N
Swollen Ankles ...	Y / N	Latex Sensitivity ...	Y / N	Epilepsy or Seizures ...	Y / N
Stroke ...	Y / N	Sinus Trouble ...	Y / N	Fainting or Dizzy Spells ...	Y / N
Diet (Special/Restricted) ...	Y / N	Radiation Therapy ...	Y / N	Nervous/Anxious ...	Y / N
Artificial Joints (hip, knee, etc.) ...	Y / N	Chemotherapy ...	Y / N	Psychiatric/Psychological Care	Y / N
Kidney Trouble ...	Y / N	Tumors ...	Y / N	Cancer ...	Y / N

8. Have you lost or gained more than 10 pounds in the past year? ..... Y / N

9. Do you have or have you had any disease, condition, or problem not listed? ..... Y / N

10. Women: Are you pregnant or think you could be pregnant? Yes _____ Months No Nursing? Y / N

11. Do you use birth control prescriptions? ..... Y / N

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 _____