Patient Name

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 Hygiene Appt.** __________ **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 in 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

Smoke/chew tobacco? 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

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches 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 your teeth all 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? Yes No

If yes, please describe ____________________

____

____

(Please complete other side)

Patient Name

MEDICAL HISTORY

Medical Alert

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 or drugs during the past two years? . . . . . Yes No
3. Are you taking any medication, drugs or pills now? . . . . . Yes No
   If yes, please list name and dosage ____
4. Have you or are you taking any medication to treat or prevent osteoporosis / bone thinning? . . . . . Yes No
   Examples: Actonel, Boniva, Fosamax, Reclast, Evista, Zometa or others.

   If yes, please list name and dosage ____ taken for how long? ____
5. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? . . . . . Yes No
   If yes, please list ____
6. Have you been a patient in the hospital in 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	Yes No
Chest Pain	Yes No	Diabetes	Yes No	S.T.D. (sexually transmitted disease)	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	H.I.V. Positive/ A.I.D.S.	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	Cold Sores/Fever Blisters	Yes No
High 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	Yes No	Chronic Cough	Yes No	Sickle Cell Disease	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Bruise Easily	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Liver Disease	Yes No
Arthritis/Rheumatism	Yes No	Allergies or Hives	Yes No	Neurological Disorders	Yes No
Cortisone Medicine	Yes No	Sinus Trouble	Yes No	Epilepsy or Seizures	Yes No
Stroke	Yes No	Tumors/ Cancer	Yes No	Fainting or Dizzy Spells	Yes No
Artificial Joints (hip, knee, etc.)	Yes No	If yes, location? ____	____	Nervous/Anxious	Yes No
Kidney Trouble	Yes No	Radiation Therapy	Yes No	Psychiatric/Psychological Care	Yes No
Diet (special/ restricted)	Yes No	Chemotherapy	Yes No		

8. Do you smoke/use tobacco products? . . . . . Yes No
9. Have you lost or gained more than 10 pounds in the past year? . . . . . Yes No
10. Do you have or have you had any disease, condition or problem not listed? . . . . . Yes No
    If yes, please list: ____
11. **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 ____