Patient Name

MEDICAL HISTORY

Patient Account No.

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. 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. Check if using your keyboard or a pen, "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
Congenital 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 Sensitivity	❒ YES ❒ NO	Yellow Jaundice	❒ YES ❒ NO
Swollen Ankles	❒ YES ❒ NO	Allergies or Hives	❒ YES ❒ NO	Neurological Disorders	❒ YES ❒ NO
Stroke	❒ YES ❒ NO	Sinus Trouble	❒ 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 use more than two pillows to sleep? ❒ YES ❒ NO
8. Have you lost or gained more than 10 pounds in the past year? ❒ YES ❒ NO
9. Do you have or have you had any disease, condition, or problem not listed ❒ YES ❒ NO

   If yes, please list: _____
10. 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 any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

1.800.925.2600

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? _____

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 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 breathe while &wake 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 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?

If yes, please describe _____

_____

_____

1.800.925.2600