

Patient Name _____
Patient Account No. _____

# DENTAL HISTORY

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 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 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 |
| 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?**

- |  |       |    |
|--|-------|----|
| 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)

**MEDICAL HISTORY**

Patient Name \_\_\_\_\_  
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
If yes, did you take any of the following? (circle if yes) Fen-Phen Pondimen Redux Other
If yes to any of the above, did you have a medical exam for heart issues? ..... 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 yes, 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/Rheumatism ..... 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
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 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 \_\_\_\_\_