Patient Name _____ **MEDICAL HISTORY**

1. Primary Care Physician_____Phone ( ) _____
   Last annual exam _____
   Have you had any medical care in the past two years? _____ Yes No
   Describe _____
2. Pharmacy Name _____Phone ( ) _____
3. Are you currently taking any medication, drugs or pills including herbal or vitamin supplements, and regular dosages of aspirin? _____ Yes No
   If yes, please list names and dosage _____
4. Have you ever pre medicated for dental treatment? _____ Yes No
5. Do you carry an Epi-Pen?_____ Yes No
6. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, Reclast or other similar drugs? _____ Yes No
7. Are you aware of having an allergic (or adverse) reaction to any substance, medication or food? If yes, please specify _____ Yes No
8. Indicate which of the following you have had, or have at present. Circle "**yes**" or "**no**" to <u>each item</u>.

Heart (surgery, disease, attack)	Yes	No	Ulcers	Yes	No	Venereal Disease	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	A.I.D.S/H.I.V. Positive	Yes	No
Congenital Heart Disease	Yes	No	Hyperthyroid	Yes	No	Cold Sores/Fever Blisters	Yes	No
Heart Murmur	Yes	No	Hypothyroid	Yes	No	Blood Transfusion	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No	Blood Disorders	Yes	No
Low Blood Pressure	Yes	No	Contact Lenses	Yes	No	Bruise Easily	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema/COPD	Yes	No	Liver Disease/ Jaundice	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Migraines	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Neurological Disorders	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Epilepsy or Seizures	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy /Hives	Yes	No	Fainting or Dizzy Spells	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hips, knee, etc)	Yes	No	Cancer	Yes	No	High Cholesterol	Yes	No
Kidney Trouble	Yes	No	Radiation/Chemotherapy	Yes	No	Low Cholesterol	Yes	No
Sinus Trouble	Yes	No	Dry Mouth	Yes	No	Lyme Disease	Yes	No
Tobacco Products	Yes	No	Hepatitis A B C	Yes	No	Psychiatric/Psychological Care	Yes	No

9. Have you lost or gained more than 10 pounds in the past year? _____ Yes No
10. Do you have any dietary restrictions? Gluten allergy or using protein shakes? _____ Yes No
11. Do you have a history of an eating disorder? _____ Yes No
12. Do you have or have you had any disease, condition or problem not listed? Yes No
    If yes, please list: _____ Yes No
13. **<u>Women</u>:** Are you pregnant or think you could be pregnant? Yes ____Months No Nursing? Yes No
14. Do you use birth control prescriptions? _____ Yes No
15. **<u>Children</u>:** Does your child have anxiety or sensory issues? _____ 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 need, 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_____

<u>History Review</u>

Dentist Signature_____ Date_____

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? _____

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?	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 _____

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)