

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? _____ Yes No
 If yes, please specify _____
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	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. **Women:** 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. **Children:** 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 _____

<p>History Review</p>
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Dentist Signature _____ Date _____

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)