

Patient Name \_\_\_\_\_  
 Patient Account No. \_\_\_\_\_

**MEDICAL HISTORY**

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        Pondimin        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 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 \_\_\_\_\_

Patient Name _____
Patient Account No. _____

# DENTAL HISTORY

Medical Alert _____
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*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)