Medical History

Patient Name _____ Medical Alert: _____

In order to serve you better, please answer the following questions:
Physician's name: _____Phone Number _____
Have you had any medical care in the past two years? _____
Describe_____

1. Have you taken any medication, drugs, pills or herbal remedies including regular dosages of aspirin? Yes No
2. Are you currently taking any medication, drugs, pills or herbal remedies, including aspirin? Yes No
   If yes, please list name and dosage:_____
3. Have you ever taken prescription medications for weight loss (diet pills)? Yes No
   If yes, did you take any of the following? Fen-Phen____ Pondimen_____ Redux____ Other_____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or similar drugs Yes No
5. Are you aware of having **an allergic** (or adverse) reaction to any substance or medication? Yes No
   If yes, please specify:_____
6. Have you been a patient in the hospital during the past five years? _____
7. Indicate which of the following you have had, or have at present. **Circle "yes" or "no" individually 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 (circle)	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/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 Spell	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

8. Have you lost or gained more than 10 pounds in the past year? _____
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 or think you could be pregnant? Yes___Months ___ No **Nursing?** Yes No
11. Do you use birth control medications? _____

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:_____

Dental History

Patient Name:_____

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 Name _____Phone Number_____
How often do you have dental examinations? _____ How often do you brush your teeth?_____ floss?_____
Have you ever used or are you 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_____

Please circle the Yes or the No to the questions below:

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Biting or chewing?	Yes	No
Sweets	Yes	No

Gums:

Have you noticed any mouth odors or bad tastes?	Yes	No
Have your parents experienced gum disease?	Yes	No
Or tooth loss?	Yes	No
Do you frequently get cold sores, blisters?	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? _____

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 you have had a serious injury to your mouth or head, please describe, including the 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	Yes	No	Difficulty in chewing on either side of the mouth?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No	Headaches, neckaches or shoulder aches?	Yes	No

Do you?

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
Clench or grind your teeth while awake or asleep	Yes	No

Are you satisfied with your teeth's appearance? _____

Would you like to keep all 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 pre-medication prior 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_____		