

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.

Name _____

Date _____

Reason for seeing the Doctor today _____

Date of last dental visit _____

Last dental cleaning _____

Last full mouth x-rays _____

What was done at your last dental visit? _____

Your previous Dentist's name _____

Address _____

How often do you see a dentist? _____

How often do you brush? _____

How often do you floss? _____

Do you use dental aids? (toothpick, electric toothbrush, etc.)

Yes No

If yes, describe _____

Do you have dental problems now? Yes No

If yes, 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 hurt or bleed? 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 become caught 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 objects with your teeth? (Pencils, pins, nails, etc.) Yes No

Mouth breath while asleep or awake? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/chew tobacco? 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 head or mouth? Yes No

If yes, 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/closing the mouth? Yes No

Difficulty chewing on either side of your mouth? Yes No

Head, neck or shoulder aches? Yes No

Are you satisfied with the way your teeth look? 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 yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, describe _____

Is there anything else about having dental treatment you would like us to know? _____

PLEASE COMPLETE OTHER SIDE

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what reason? _____

Physician's name _____ Address _____

Have you taken any medication or drugs during the past two years? Yes No

Are you currently taking any medication, drugs or pills? Yes No If yes, list name and dosage below:

1. name: _____ dosage: _____ 2. name: _____ dosage: _____ 3. name: _____ dosage: _____

4. name: _____ dosage: _____ 5. name: _____ dosage: _____ 6. name: _____ dosage: _____

Are you aware of having an allergic or adverse reaction to any medication or substance? Yes No

If yes, describe _____

Have you been a patient in the hospital during the past five years? Yes No If yes, explain _____

Please indicate which of the following you have had, or have at present. Circle Y for Yes, N for No.

Heart Attack, Surgery or Disease ..	Y	N	Ulcers	Y	N	Hepatitis A (infectious) B (serum) ..	Y	N
Chest Pain or Angina	Y	N	Diabetes	Y	N	Venereal Disease	Y	N
Congenital Heart Disease	Y	N	Thyroid Problems	Y	N	A.I.D.S.	Y	N
Heart Murmur	Y	N	Glaucoma	Y	N	H.I.V. Positive	Y	N
High Blood Pressure	Y	N	Auto Immune Deficiency	Y	N	Cold Sores/Fever Blisters	Y	N
Mitral Valve Prolapse	Y	N	Emphysema	Y	N	Blood Transfusion	Y	N
Artificial Heart Valve	Y	N	Chronic Cough	Y	N	Hemophilia	Y	N
Heart Pacemaker	Y	N	Tuberculosis	Y	N	Sickle Cell Disease	Y	N
Rheumatic Fever	Y	N	Asthma	Y	N	Bruise Easily	Y	N
Arthritis/Rheumatism	Y	N	Hay Fever	Y	N	Liver Disease or Jaundice	Y	N
Cortisone Medicine	Y	N	Latex Sensitivity	Y	N	Anemia	Y	N
Swollen Ankles	Y	N	Allergies or Hives	Y	N	Neurological Disorders	Y	N
Stroke	Y	N	Sinus Trouble	Y	N	Epilepsy or Seizures	Y	N
Diet (Special/Restricted)	Y	N	Radiation Therapy	Y	N	Fainting or Dizzy Spells	Y	N
Artificial Joints (Hip, Knee, etc.)	Y	N	Chemotherapy	Y	N	Nervous/Anxious	Y	N
Kidney or Bladder Trouble	Y	N	Tumors	Y	N	Psychiatric/Psychological Care	Y	N

Do you have or have you had any disease, condition, or problem not listed above? Yes No

If yes, describe _____

Do you use more than two pillows to sleep? Yes No Have you lost or gained more than 10 pounds in the past year? Yes No

Women: Are you pregnant? Yes - Months _____ No Nursing? Yes No Taking birth control Pills? Yes No

History Review (by Doctor):

I understand the information on both sides of this form 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. If further information is 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. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with patient. I further authorize and consent that Doctor choose and employ such assistance as deemed fit.

Patient Signature _____ Date _____

Parent/Responsible Party Signature _____ Date _____