

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 \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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, etc.) ..... 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

Do you feel nervous about having dental treatment? ..... Yes No

Please describe \_\_\_\_\_

Have you ever had an upsetting dental experience? ..... Yes No

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 \_\_\_\_\_

**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

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 replace your silver fillings? ..... Yes No

Would you like to keep all of your teeth all of your life? .... Yes No

(Please complete other side)

Patient Name

**MEDICAL HISTORY**

Patient Account No.

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  
 If yes, please list name and dosage \_\_\_\_\_
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 bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ..... Yes No  
 If yes, please list name and dosage \_\_\_\_\_
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? ..... Yes No
7. 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 | Cancer .....                     | Yes | No |
8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
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 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 \_\_\_\_\_