

MEDICAL HISTORY

Patient Name _____
 Patient Account No. _____

Medical Alert _____

1. Have you been under the care of a medical doctor during the past two years?..... Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____
 2. Have you taken any medication or drugs during the past two years?..... Yes No
 3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines?..... Yes No
 If yes, please list name and dosage _____
 4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phenentermine); Pondimin (fenfluramine); and Redux (dexfenfluramine)?..... Yes No
 If yes to the above, did you have a medical exam for heart issues?..... Yes No
 5. Are you aware of having an allergic (or adverse) reaction to any medication or substance?..... Yes No
 If yes, please list: _____
 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..... | Yes | No |
| Heart Murmur..... | Yes | No | Glaucoma..... | Yes | No | H.I.V. Positive..... | Yes | No |
| High Blood Pressure..... | Yes | No | Contact lenses..... | Yes | No | Cold Sores/Fever Blisters..... | Yes | No |
| Mitral Valve Prolapse..... | Yes | No | Emphysema..... | Yes | No | Blood Transfusion..... | Yes | No |
| Artificial Heart Valve..... | Yes | No | Chronic Cough..... | Yes | No | Hemophilia..... | Yes | No |
| Heart Pacemaker..... | Yes | No | Tuberculosis..... | Yes | No | Sickle Cell Disease..... | Yes | No |
| Rheumatic Fever..... | Yes | No | Asthma..... | Yes | No | Bruise Easily..... | Yes | No |
| Arthritis/Rheumatism..... | Yes | No | Hay Fever..... | Yes | No | Liver Disease..... | Yes | No |
| Cortisone Medicine..... | Yes | No | Latex Sensitivity..... | Yes | No | Yellow Jaundice..... | Yes | No |
| Swollen Ankles..... | Yes | No | Allergies or Hives..... | Yes | No | Neurological Disorders..... | Yes | No |
| Stroke..... | Yes | No | Sinus Trouble..... | Yes | No | Epilepsy or Seizures..... | Yes | No |
| Diet (Special/Restricted)..... | Yes | No | Radiation Therapy..... | Yes | No | Fainting or Dizzy Spells..... | Yes | No |
| Artificial Joints (hip, knee, etc.).... | Yes | No | Chemotherapy..... | Yes | No | Nervous/Anxious..... | Yes | No |
| Kidney Trouble..... | Yes | No | Tumors..... | Yes | No | Psychiatric/Psychological Care..... | Yes | No |
8. Do you use more than two pillows to sleep?..... 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 may be pregnant? Yes, _____ Months No **Nursing?** Yes No
 12. **Women:** Do you use birth control medications?..... 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 dentist of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

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 _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

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 _____

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)