



PATIENT NAME _____	D.O.B. _____
--------------------	--------------

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 \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Are you currently taking any medication, drugs, or pills?  Yes  No If so, what? What dosage? Reason?  
 \_\_\_\_\_

Are you aware of having an allergic or unusual reaction to any medication or substance?  Yes  No  
(like aspirin, codeine, penicillin, novacaine, sulfa, erythromycin or tetracycline)?  
 If yes, what? \_\_\_\_\_

Have you ever had any serious illness or operation? If so, explain \_\_\_\_\_  
 \_\_\_\_\_

**Please indicate which of the following you have had or have at present (circle Y for Yes; or N for No)**

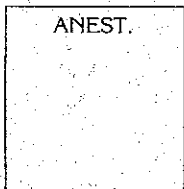
- |  |                                      |   |
|--|--------------------------------------|---|
| Heart Attack/Stroke ..... Y N                | Diabetes ..... Y N                   | Tumors ..... Y N                          |
| Heart Surgery/Pacemaker ..... Y N            | Thyroid Problems .....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

COMMENTS \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have an alcohol sensitivity or are you a recovering alcoholic?  Yes  No  
 Do you habitually use controlled substances other than those prescribed by physician?  Yes  No  
 Have you lost or gained more than 10 pounds in the last year?  Yes  No  
 Do you bleed for a long time after a tooth extraction or after an injury?  Yes  No  
 Do you have or have you had any disease, condition, or problem not listed above? If yes, describe \_\_\_\_\_

Would you like to speak to the Doctor privately about any problem?  Yes  No

Women: Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No



*(Please continue on other side.)*



## MEDICAL HISTORY



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 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

How often do you see a dentist? \_\_\_\_\_ How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Do you use dental aids (toothpick, Interplak, etc.)? \_\_\_\_\_

Have you lost any teeth?  Yes  No Have they been replaced?  Yes  No Are you happy with the replacement?  Yes  No

**Please indicate which of the following you have had or have at present (circle Y for Yes, or N for No)**

**Are any of your teeth sensitive to:**

Hot or cold? ..... Y N

Sweets? ..... Y N

Biting or chewing? ..... Y N

Have you noticed any mouth odors or bad tastes? ..... Y N

Do you frequently get cold sores, blisters or any other oral lesions? ..... Y N

Do your gums hurt or bleed? ..... Y N

Have your parents experienced any gum disease or tooth loss? ..... Y N

Have you noticed any loose teeth or change in your bite? ..... Y N

Does food become caught between your teeth? ..... Y N

If yes, where? \_\_\_\_\_

**Do you:**

Clench or grind your teeth while awake or asleep? ..... Y N

Bite your lips or cheeks regularly? ..... Y N

Hold objects with your teeth (Pencils, pins, nails, etc.) ..... Y N

Mouth breathe while asleep or awake? ..... Y N

Have tired jaws, especially in the morning? ..... Y N

Smoke/chew tobacco? ..... Y N

**Have you ever had:**

Orthodontic treatment? ..... Y N

Oral Surgery? ..... Y N

Periodontal treatment? ..... Y N

Your teeth ground or the bite adjusted? ..... Y N

A bite plate or mouth guard? ..... Y N

A serious injury to the head or mouth? ..... Y N

If yes, describe, including the cause \_\_\_\_\_

**Have you experienced:**

Clicking or popping of the jaw? ..... Y N

Jaw Pain (joint, ear, side of face)? ..... Y N

Difficulty opening/closing the mouth? ..... Y N

Difficulty chewing on either side of your mouth? ..... Y N

Head, neck or shoulder aches? ..... Y N

Are you satisfied with the way your teeth look? ..... Y N

Would you like to keep all of your teeth all of your life? ..... Y N

Do you feel nervous about having dental treatment? ..... Y N

If yes, what is your biggest concern? \_\_\_\_\_

Have you ever had an upsetting dental experience? ..... Y N

If yes, describe \_\_\_\_\_

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

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 CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. 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.

Patient's or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

# DENTAL HISTORY