

# 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 medications, drugs or pills now? ..... Yes No  
 If yes, please list name and dosage \_\_\_\_\_
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ..... Yes No  
 If yes, please list: \_\_\_\_\_
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. 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 (infectious) B (serum) .... 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

7. Do you use more than two pillows to sleep? ..... 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?** Yes, \_\_\_ Months No      **Nursing** Yes No      **Taking birth control pills?** 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 \_\_\_\_\_

Patient Name

# DENTAL HISTORY

Patient Account No.

Medical Alert

*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 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 and 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? Yes No

(pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? 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 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, neck aches, 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)