MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions!

Are you under a physician's care now? __ Yes __ No If yes, please explain: ____________________________

Have you ever been hospitalized or had a major operation? __ Yes __ No If yes, please explain: ____________________________

Have you ever had a serious head or neck injury? __ Yes __ No If yes, please explain: ____________________________

Do you take, or have you taken, Phen-Fen or Redux? __ Yes __ No If yes, please explain: ____________________________

Are you on a special diet? __ Yes __ No If yes, please explain: ____________________________

Are you taking any medications, pills or drugs? __ Yes __ No If yes, please list: ________________________________

____

WOMEN ONLY: Are you: Pregnant/Trying to get pregnant? __ Yes __ No Taking oral contraceptives? __ Yes __ No

Nursing? __ Yes __ No

Are you allergic to any of the following? __ Aspirin __ Penicillin __ Codeine __ Acrylic __ Metal __ Latex

__ Local Anesthetic __Other: (please list) ____

Please check all that apply:

AIDS/HIV Positive	__ Yes	__ No	Emphysema	__ Yes	__ No	Leukemia	__ Yes	__ No
Alzheimer's disease	__ Yes	__ No	Epilepsy or Seizures	__ Yes	__ No	Liver Disease	__ Yes	__ No
Anaphylaxis	__ Yes	__ No	Excessive Bleeding	__ Yes	__ No	Low Blood Pressure	__ Yes	__ No
Anemia	__ Yes	__ No	Excessive Thirst	__ Yes	__ No	Lung Disease	__ Yes	__ No
Angina	__ Yes	__ No	Fainting/Dizzy Spells	__ Yes	__ No	Mitral Valve Prolapse	__ Yes	__ No
Arthritis/Gout	__ Yes	__ No	Frequent Cough	__ Yes	__ No	Psychiatric Care	__ Yes	__ No
Artificial Heart Valve	__ Yes	__ No	Frequent Diarrhea	__ Yes	__ No	Radiation Treatment	__ Yes	__ No
Artificial Joint	__ Yes	__ No	Frequent Headaches	__ Yes	__ No	Rheumatic Fever	__ Yes	__ No
Asthma	__ Yes	__ No	Genital Herpes	__ Yes	__ No	Shingles	__ Yes	__ No
Blood Disease	__ Yes	__ No	Glaucoma	__ Yes	__ No	Sickle Cell Disease	__ Yes	__ No
Blood Transfusion	__ Yes	__ No	Hay Fever	__ Yes	__ No	Sinus Trouble	__ Yes	__ No
Breathing Problems	__ Yes	__ No	Heart Attack/Failure	__ Yes	__ No	Spina Bifida	__ Yes	__ No
Bruise Easily	__ Yes	__ No	Heart Trouble/Disease	__ Yes	__ No	Stomach Disease	__ Yes	__ No
Cancer	__ Yes	__ No	Heart Murmur	__ Yes	__ No	Swelling of Limbs	__ Yes	__ No
Chemotherapy	__ Yes	__ No	Heart Pace Maker	__ Yes	__ No	Thyroid Disease	__ Yes	__ No
Chest Pains	__ Yes	__ No	Hemophilia	__ Yes	__ No	Tonsillitis	__ Yes	__ No
Cold Sores/Blister	__ Yes	__ No	Hepatitis A	__ Yes	__ No	Tuberculosis	__ Yes	__ No
Congenital Heart Disorder	__ Yes	__ No	Hepatitis B or C	__ Yes	__ No	Tumors or Growths	__ Yes	__ No
Convulsions	__ Yes	__ No	Herpes	__ Yes	__ No	Ulcers	__ Yes	__ No
Cortisone Medicine	__ Yes	__ No	High Blood Pressure	__ Yes	__ No	Venereal Disease	__ Yes	__ No
Diabetes	__ Yes	__ No	Hypoglycemia	__ Yes	__ No	Yellow Jaundice	__ Yes	__ No
Drug Addiction	__ Yes	__ No	Irregular Heartbeat	__ Yes	__ No	Other: ________________________________		
Easily Winded	__ Yes	__ No	Kidney Problems	__ Yes	__ No	________________________________		

Do you have or have you had any disease, condition or problem not listed above? __ Yes __ No If yes, please explain ______________________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

Signature of Patient or Guardian ____ Date ______________

DENTAL HISTORY

Please answer the following questions in regards to your current and previous dental history. Thank you!

Reason for your visit today? ____

Date of last dental visit _______________ Last dental cleaning _______________ Last full mouth x-ray _______________

What was done at your last dental visit? ____

Previous Dentist's Name: ____ Telephone: _______________________

Address: ____ City/St/Zip: ____

How often do you have dental cleanings and exams? _______________ How often do you brush your teeth? ________________

How often do you floss? ____________ Other dental aids used? (water flosser, 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 / chewing? Yes __ No __

Have you noticed bad odor/taste? Yes __ No __

Do you get cold sores, blisters or other oral lesions? Yes __ No __

Do your gums bleed or hurt? Yes __ No __

Have your parents experienced gum disease / tooth loss? Yes __ No __

Have you noticed change in your bite? Yes __ No __

Does food tend to become caught in your teeth? Yes __ No __

If yes, where? _____________________________

Do you:

Clench or grind your teeth? Yes __ No __

Bite your lip or cheeks? Yes __ No __

Hold foreign objects with your teeth? (pencils, nails, pipe) Yes __ No __

Mouth breathe while awake/asleep? Yes __ No __

Have a tired jaw in the morning? Yes __ No __

Snore or have any other sleeping disorders? Yes __ No __

Do you or have you used a CPAP? Yes __ No __

Smoke/chew tobacco or use any other tobacco product? Yes __ No __

Have you ever had:

Orthodontic treatment? Yes __ No __

Oral Surgery? Yes __ No __

Periodontal treatment? Yes __ No __

Your teeth ground or a bite adjustment? Yes __ No __

A bite plate/mouth guard? Yes __ No __

A serious injury to the mouth or head? Yes __ No __

If so, please explain: _________________________________

____

Have you ever experienced:

Clicking or popping of the jaw? Yes __ No __

Pain? (joint, ear, side of face) Yes __ No __

Difficulty opening or closing of your mouth? Yes __ No __

Headaches, neck aches? Yes __ No __

Sore muscles (neck/shoulder)? Yes __ No __

Dental Anxiety? Yes __ No __

Are you satisfied with your teeth's appearance?

Please explain: ___________________________________

Have you had an upsetting dental experience?

Please explain: ___________________________________

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Are there any other concerns about dental treatment you would like us to know? (Please comment)

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CONTINUED ON BACKSIDE →