MEDICAL HISTORY

Patient's Name _____

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 _____
2. Have you been a patient in the hospital during the past **five** years? ..... Yes No
3. Are you taking any medication, drugs, pills, herbal supplements, or vitamins? ..... 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
   (Ex: Penicillin, Latex) If yes, please list: _____
5. Indicate which of the following you have had:

Heart (surgery, disease, attack)	Yes	No	Ulcers	Yes	No	Hepatitis A, B, or C	Yes	No
Chest Pain/Heart Pain/Angina	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 Blister	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

6. Have you ever had an illness that suppresses or weakens the immune system? ..... Yes No
7. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
8. Have you ever used **tobacco** products? ..... Yes No
   If so, how often? _____
9. Do you or have you ever consumed alcoholic beverages? ..... Yes No
   If so, how often? _____
10. Do you have or have you had any disease, condition, or problems not listed? ..... Yes No
    If yes, please list: _____
11. 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 dentist of any change in my health or medication(s).

Patient/Guardian Signature _____ Date _____

HISTORY REVIEW

Doctor Signature _____ Date _____

DENTAL HISTORY

Patient's Name _____

- What is the reason for your visit today? _____
  _____
- Are you satisfied with your teeth's appearance? _____ If not, what would you change? (Ex: whiter, longer, straighter, etc.)
  _____
- Do you have any dental problems now? Yes No
  If yes, please describe: _____
  _____

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: _____ Phone: _____
How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
What kind of toothbrush do you use? _____ What kind of toothpaste do you use? _____
Do you use a prescription fluoride? Yes No If yes, what kind? _____
What other dental aids do you use? (Interplak, Waterpik, Listerine, toothpick, electric toothbrush, etc.) _____
_____

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? _____		

Have you ever had:		
Orthodontic treatment (Braces)?	*Yes*	*No*
Oral surgery (Wisdom teeth removed)?	*Yes*	*No*
Periodontal (Gum) 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
Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain (TMJ, 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

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, nail, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No

Do you feel nervous about having dental treatment?	Yes	No
Have you ever had an upsetting dental experience?	Yes	No
Would you like to keep all of your teeth all of your life?	*Yes*	*No*
Is there anything else about having dental treatment that you would like us to know?	*Yes*	*No*

If so, what is your biggest concern? _____
If yes, please describe: _____
If yes, please describe: _____