Patient Name _____

MEDICAL HISTORY

1. Physician's Name _____ Phone ( )_____

Have you had any medical care within the past two years? ◯ Yes ◯ No

Describe_____

2. Have you taken any medication or drugs during the past two years? ◯ Yes ◯ No

3. Are you currently taking any medications, drugs, pills or herbal remedies, including regular dosage of aspirin? ◯ Yes ◯ No

If yes, please list name and dosage_____

4. Have you ever taken prescription medications for weight loss (diet pills)? ◯ Yes ◯ No

If yes, did you take any of the following? (Circle if yes) ☐ Fen-Phen ☐ Pondimen ☐ Redux ☐ Other _____

If yes, to any of the above, did you have a medical exam for heart issues? ◯ Yes ◯ No

5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Bonivia or other similar drugs? ◯ Yes ◯ No

6. Are you aware of having an allergic (**or adverse**) reaction to any substance or medication? ◯ Yes ◯ No

If yes, please specify_____

7. Have you been a patient in the hospital during the past five years? ◯ Yes ◯ No

8. Please indicate which of the following you have had or have at present.

☐	Heart (Surgery, Disease, Attack	☐	Ulcers	☐	Hepatitis ◯ A ◯ B ◯ C
☐	Congenital Heart Disease	☐	Diabetes	☐	Venereal Disease
☐	Heart Murmur	☐	Thyroid Problems	☐	AIDS / HIV Positive
☐	High Blood Pressure	☐	Glaucoma	☐	Cold Sores / Fever Blisters
☐	Low Blood Pressure	☐	Contact Lenses	☐	Hemophilia
☐	Mitral Valve Prolapse	☐	Emphysema	☐	Sickle Cell Disease
☐	Artificial Heart Valve / Pacemaker	☐	Tuberculosis	☐	Bruise Easily
☐	Rheumatic Fever	☐	Asthma	☐	Liver Disease / Yellow Jaundice
☐	Arthritis / Rheumatism	☐	Hay Fever / Allergy / Hives	☐	Neurological Disorders
☐	Cortisone Medicine	☐	Latex Sensitivity	☐	Epilepsy or Seizures
☐	Stroke	☐	Sinus Trouble	☐	Fainting / Dizzy Spells
☐	Special / Restricted Diet	☐	Radiation Therapy	☐	Nervous / Anxious
☐	Artificial Joints _____	☐	Chemotherapy	☐	Psychiatric / Psychological Care
☐	Kidney Trouble	☐	Tumors		

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 could be pregnant? ◯ Yes ◯ No _____ Months **Nursing?** ◯ Yes ◯ No

12. Do you use birth control prescriptions? ◯ 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/Parent/Guardian Signature_____ Date_____

History Review

Dentist Signature _____ Date _____

DENTAL HISTORY

Patient Name_____

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?_____
Have you ever used or are currently using topical fluoride? ◯ Yes ◯ No
What other dental aids do you use? (Interplak, toothpick, etc.) ◯ Yes ◯ No

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
Do you have 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 your between teeth? ◯ Yes ◯ No
If yes, where? _____

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? ◯ Yes ◯ No
If yes, which side: ◯ Right ◯ Left
Headaches, neck aches or shoulder aches? ◯ Yes ◯ No

Do you:
Clench or grind while awake or asleep? ◯ Yes ◯ No
Bite your lips or cheeks regularly? ◯ Yes ◯ No
Mouth breathe while awake or asleep? ◯ Yes ◯ No
Have tired jaws, especially in the morning? ◯ Yes ◯ No
Do you smoke? ◯ Yes ◯ No
Chew tobacco? ◯ Yes ◯ No

Are you satisfied with your teeth's appearance? ◯ Yes ◯ No
Would you like to keep all of your teeth? ◯ Yes ◯ No
all of your life? ◯ Yes ◯ No
Do you feel nervous about having dental care? ◯ Yes ◯ No
If so, what is your biggest concern?_____
_____
Have you ever had an upsetting dental visit? ◯ Yes ◯ No
If yes, please describe_____

Have you ever been told to take a pre-medication prior to dental treatment? ◯ Yes ◯ No
Is there anything else about having dental treatment that you would like us to know? If yes, please describe.
_____

SUBMIT