DENTAL HISTORY

Patient Name _____ Birthdate _____

Welcome! *So that we may provide you with the best possible care, please complete both sides of this dental/medical form. All Information will be completely confidential.*

Date of Last Dental Visit: _____ Last Full Mouth X-Rays: _____

What was done at your last dental visit? _____

Previous Dentist's Name and Telephone Number: _____

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 any dental problems now? ..... Yes / No
If yes, please describe: _____

Are any of your teeth sensitive to:
- Hot or cold? ..... Yes / No
- Biting or Chewing? ..... Yes / No
- Sweets? ..... Yes / No

Have you noticed any mouth odors or bad tastes? ..... Yes / No

Does your mouth feel dry? ..... Yes / No

Do your gums bleed or hurt? ..... Yes / No

Have your parents experienced:
- Gum Disease? ..... Yes / No
- Tooth loss? ..... Yes / No

Have you noticed any loose teeth? ..... Yes / No
If yes, where? _____

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
- Habitually hold foreign objects with your teeth? ..... Yes / No
  (pencils, pipe, pins, fingernails)
- Have sore jaws, especially in the morning? ..... Yes / No
- Snore or have any other sleeping disorders? ..... Yes / No
- Use tobacco products? ..... Yes / No
  If yes, what kind and how much? _____

Have you ever had:
- Braces? ..... Yes / No
- Teeth Removed? ..... Yes / No
- Jaw Surgery? ..... Yes / No
- Gum Disease Treatment? ..... Yes / No
- Mouthguard? ..... Yes / No
- Serious injury to the mouth or head? ..... Yes / No

If so, please describe: _____

Have you ever experienced:
- Clicking or popping in the jaw? ..... Yes / No
- Pain? (joint, ear, side of face) ..... Yes / No
- Difficulty in opening or closing mouth ..... Yes / No
- Difficulty in chewing on either side of 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 whiter teeth? ..... 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 the other side

MEDICAL HISTORY

Patient Name: **Birthdate:**

Have you been under the care of a medical doctor during the past two years (other than annual checkups?) ..... Yes / No

Physician's Name

Physician's Telephone

Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines? ..... Yes / No

If yes, please list:

Have you ever taken any prescription drugs for bone density?..... Yes / No
Examples: Fosamax, Boniva or Actonel

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

If yes, please list:

Have you been a patient in the hospital during the last five years? Yes / No

If yes, please explain:

Have you ever taken or been told you need antibiotics prior to dental appointments for premedication? ..... Yes / No

WOMEN: Are you pregnant or think you may be pregnant? ..... Yes / No

If yes, how many months?

Nursing?

WOMEN: Do you use birth control medications? ..... Yes / No

If yes, what kind?

Indicate which of the following you have had, or have at the present time. Circle "Yes" or "No" for each of them.

Artificial Heart Valve	Yes / No	Cancer: Chemotherapy	Yes / No
Chest Pain	Yes / No	Cancer: Radiation	Yes / No
Heart Attack	Yes / No	Growths: Abnormal	Yes / No
Heart Disease	Yes / No		
Heart Murmur	Yes / No	High Blood Pressure	Yes / No
Heart Surgery	Yes / No	Hypertension	Yes / No
Mitral Valve Prolapse	Yes / No	Low Blood Pressure	Yes / No
Pacemaker	Yes / No		
Rheumatic Fever	Yes / No	A.I.D.S.	Yes / No
		Autoimmune Disease	Yes / No
Arthritis/ Rheumatism	Yes / No	Hepatitis A,B,C.....	Yes / No
Cortisone Medicine	Yes / No	HIV Positive	Yes / No
		STDS	Yes / No
Allergies or Hives	Yes / No		
Asthma	Yes / No	Jaundice	Yes / No
Chronic Cough	Yes / No	Liver Disease	Yes / No
Emphysema	Yes / No		
Hay Fever	Yes / No	Epilepsy/Seizures	Yes / No
Lung Disease	Yes / No	Fainting/Dizziness	Yes / No
Respiratory Problems	Yes / No	Head Injuries	Yes / No
Sinus Problems	Yes / No	Nervous/Anxious	Yes / No
Tuberculosis	Yes / No	Neurological Disorders	Yes / No
Anemia	Yes / No	Artificial Joints-hip,knee,etc	Yes / No
Blood Disease	Yes / No	Cold Sores	Yes / No
Blood Thinners	Yes / No	Diabetes	Yes / No
Blood Transfusions	Yes / No	Glaucoma	Yes / No
Bruises Easily/Excessively ...	Yes / No	Kidney Disease	Yes / No
Hemophilia	Yes / No	Latex Sensitivity	Yes / No
Sickle Cell Disease	Yes / No	Stroke	Yes / No
		Thyroid Problems	Yes / No
Stomach Problems	Yes / No		
Ulcers	Yes / No		

Do you have or have you had any disease, condition, or problem not listed?
If yes, please describe: ..... 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 changes in my health or medication.

Patient/Guardian Signature Date

History Review

Dentist Signature Date

Please complete the other side