DENTAL HISTORY

Patient Name
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-ray**_____

What was done at your last dental visit?_____

_____

Previous Dentist's Name_____

Address _____

Telephone _____

How often do you have dental examinations?_____

How often fo 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: (circle answer) Hot Cold Sweets Biting or Chewing

Have you noticed any mouth odors or bad tastes?.....Y N
Have your parents experienced gum disease or tooth loss? .....Y N
Have you noticed any loose teeth or change in your bite?.....Y N
Does food tend to become caught between your teeth? .....Y N
If yes, where? _____

Do you frequently get cold sores, blisters .....Y N
or any other oral lesions?.....Y N
Do your gums bleed or hurt? .....Y N

Do you:

Clench or grind your teeth while awake or sleep?.....Y N
Bite your lips or cheeks regularly?.....Y N
Hold foreign objects with your teeth? .....Y N
(pencils, pipe, pins, nails, fingernails)

Mouth breathe while awake or asleep?.....Y N
Have tired jaws, especially in the morning?.....Y N
Snore or have any other sleeping disorders? .....Y N

Have you ever had:

Orthodontic treatment? .....Y N
Oral Surgery?.....Y N
Your teeth ground or the bite adjusted? .....Y N
A serious injury to the mouth or head?.....Y N
If so, describe including cause _____

Periodontal teatment? .....Y N
A bite plate or mouth guard? .....Y N

Have you experienced:

Clicking or popping of the jaw?.....Y N
Difficulty in opening or closing the mouth? .....Y N
Headaches, neckaches, or shoulder aches? .....Y N

Pain? (joint, ear, side of face) .....Y N
Difficulty in chewing on either side of the mouth? .....Y N
Sore muscles (neck, shoulder)? .....Y N

Are you satisfied with your teeth's appearance?.....Y N
Would you like to keep all of your teeth all of your life?.....Y N
Do you feel nervous about having dental treatment?.....Y N
If so, what is your biggest concern? _____
Have you ever had any upsetting dental experiences?.....Y N
If yes, please describe _____
Is there anything else about having dental treatment that you would like us to know?.....Y N
If yes, please describe _____

HEALTH HISTORY

Answer all questions by circling Yes (Y) or No (N) All responses are kept confidential

1. Have you been under the care of a medical doctor during the past two years? ..... Y N
   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? ..... Y N
3. Please list any and all medications you are currently taking, including prescription medication, diet drugs, over the counter ..... Y N
   medications, herbal or holistic remedies, vitamins or minerals: _____
   _____
4. Are you taking or have you ever taken: Bisphosphonatics for Osteoporosis, Multiple Myeloma or other Caners ..... Y N
   (Fosamax, Aetonel, Bonica, Aredia, Zometa)
5. Are you taking or have you ever taken any prescription drugs for weight loss, including Fen-Phen (Fenfluramine-Phentermine)... Y N
   Pondimen (Fenfluramine) and Redux (Dexfenfluramine)
6. Are you allergic to or have you had adverse reaction to any medication or substance (i.e. latex)? ..... Y N
   If yes, please list: _____
7. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe ..... Y N
   _____

8. DO YOU OR HAVE YOU EVER HAD:

Rheumatic Fever or Rheumatic Heart Disease	Y N	Kidney Disease?	Y N
Cardiovascular Disease	Y N	Diabetes?	Y N
Chest Pain	Y N	Thyroid Disease?	Y N
Congenital Heart Disease	Y N	Arthritis?	Y N
Lung Disease (Asthma, Emphysema, Chronic Cough)	Y N	Stomach Ulcers or Colitis?	Y N
Seizures, Convulsions, Epilepsy, Fainting, Dizziness	Y N	Glaucoma?	Y N
Bleeding Disorder, Anemia, Bleeding Tendency	Y N	Contact Lenses/Hearing Aids?	Y N
Blood Transfusion? Do you bruise easily?	Y N	Osteoporosis	Y N
Liver Disease (Jaundice)	Y N	Implants (Heart valve, Pacemaker, Hip, Knee, Breast)	Y N
Hepatitis A B C (circle one)	Y N	Radiation (x-ray) treatment for Cancer	Y N
Artificial Joints (hip, knee, etc...)	Y N	Sinus or Nasal problems?	Y N
A.I.D.S. / H.I.V. Positive	Y N	Any disease, drug or transplant operation that has depressed your immune system?	Y N

9. Do you smoke or chew tobacco? ..... Y N How much per day? _____ How Long? _____

10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may effect the care we provide? ..... Y N
11. Have you had any serious problems associated with any previous dental treatment? ..... Y N
12. Have you or an immediate family member had any problems associated with intravenous Anesthesia? ..... Y N
13. Do you have any other disease, conditions or problems not listed above that you think the Doctor should know about? ..... Y N
14. Do you wish to talk to the Doctor privately about anything? ..... Y N
15. **Women:** Are you pregnant or think you may be pregnant? Yes _____ Months No Nursing? Yes No
16. **Women:** Do you use birth control medications? Yes No

I understand the importance of truthful Health History to assist the doctor in providing the best care possible.
I have had the opportunity to discuss my Health History with my doctor.

_____ _____
Date Signature of Person Completing Health History

For Completion by the Doctor

Medical Clearance Necessary ..... Y N
Allergies _____
PMH _____

_____
Dentist Signature Date