PATIENT NAME

DENTAL HISTORY

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-rays** _____

What was done at your last dental visit? _____

_____

Dentist's Name_____

Address _____ State _____ Zip _____

Telephone _____

Referred by: _____

How often do you have dental examinations? _____

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
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?

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?_____

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, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Concerning oral hygiene:

How often do you brush your teeth?
____ times per day. When?_____
Do you use a hard, medium or soft bristle brush? Which?_____
Do you use dental floss, rubbertip or Stimudents? Which?_____
Do you use anything else to clean your teeth? If so what?_____
Have you ever had oral hygiene instructions? Yes No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment? When_____	Yes	No
Vincents disease or Trench mouth?	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 on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with the appearance or your teeth?

Would you like to keep all of your teeth all of your life?	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 other side)

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? _____ Yes No

If yes, for what? _____

Physician's Name _____ Phone_____

Address _____ City_____ State_____ Zip_____

Are you taking any medication, drugs or pills now?_____ Yes No

Name of Medication	Dosage	Name of Medication	Dosage

Are you aware of having 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 past five years? _____ Yes No

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)____ Yes No
Chest Pain _____ Yes No
Congenital Heart Disease _____ Yes No
Heart Murmur _____ Yes No
High Blood Pressure_____ Yes No
Mitral Valve Prolapse _____ Yes No
Artificial Heart Valve _____ Yes No
Heart Pacemaker _____ Yes No
Rheumatic Fever_____ Yes No
Arthritis/Rheumatism _____ Yes No
Cortisone or Steroids _____ Yes No
Smoke _____ Yes No
Diet (Special/Restricted)_____ Yes No
Artificial Joints (hip, knee, etc.) ____ Yes No
Kidney Trouble_____ Yes No
Ulcers _____ Yes No

Diabetes _____ Yes No
Thyroid Problems _____ Yes No
Glaucoma _____ Yes No
Contact Lenses _____ Yes No
Emphysema _____ Yes No
Chronic Cough_____ Yes No
Tuberculosis _____ Yes No
Asthma _____ Yes No
Hay Fever _____ Yes No
Latex Sensitivity _____ Yes No
Allergies or Hives _____ Yes No
Sinus Trouble _____ Yes No
Radiation Therapy _____ Yes No
Chemotherapy_____ Yes No
Tumors _____ Yes No
Cancer_____ Yes No

Hepatitis A (infectious), B (serum), C _ Yes No
A.I.D.S. _____ Yes No
H.I.V. Positive _____ Yes No
Cold Sores/Fever Blisters _____ Yes No
Blood Transfusion _____ Yes No
Hemophilia _____ Yes No
Sickle Cell Disease_____ Yes No
Liver Disease _____ Yes No
Neurological Disorders _____ Yes No
Epilepsy or Seizures _____ Yes No
Fainting or Dizzy Spells _____ Yes No
Nervous/Anxious _____ Yes No
Psychiatric/Psychological Care ____ Yes No
History of Substance Abuse _____ Yes No

Do you have or have you had any disease, condition, or problem not listed?_____ Yes No

If yes, please list:_____

Women. Are you: Pregnant? Yes,____ Months No Nursing? Yes No Taking birth control pills? Yes No

Have you undergone or are you undergoing menopause? 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 doctor of any change in my health or medication.

Patient/Guardian Signature_____ Date_____

History Review

Dentist Signature_____ Date_____