| Patient Name | MEDICAL HISTORY |
|---|---|
| Patient Account No. | Medical Alert |

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 medication, drugs, pills or herbal remedies, including regular dosages 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, Boniva 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. 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 | Ulcers ..... | Yes | No | Hepatitis A B C (circle) ... | Yes | No |
| Chest Pain ..... | Yes | No | Diabetes ..... | Yes | No | Venereal Disease ..... | Yes | No |
| Congenital Heart Disease ..... | Yes | No | Thyroid Problems ..... | Yes | No | A.I.D.S./H.I.V. Positive ..... | Yes | No |
| Heart Murmur ..... | Yes | No | Glaucoma ..... | Yes | No | Cold Sores/Fever Blisters ..... | Yes | No |
| High/Low Blood Pressure ..... | Yes | No | Contact lenses ..... | Yes | No | Blood Transfusion ..... | Yes | No |
| Mitral Valve Prolapse ..... | Yes | No | Emphysema ..... | Yes | No | Hemophilia ..... | Yes | No |
| Artificial Heart Valve/Pacemaker ..... | Yes | No | Chronic Cough ..... | Yes | No | Sickle Cell Disease ..... | Yes | No |
| Rheumatic Fever ..... | Yes | No | Tuberculosis ..... | Yes | No | Bruise Easily ..... | Yes | No |
| Arthritis/Rheumatism ..... | Yes | No | Asthma ..... | Yes | No | Liver Disease/Yellow Jaundice .. | Yes | No |
| Cortisone Medicine ..... | Yes | No | Hay Fever/Allergy/Hives ..... | Yes | No | Neurological Disorders ..... | Yes | No |
| Swollen Ankles ..... | Yes | No | Latex Sensitivity ..... | Yes | No | Epilepsy or Seizures ..... | Yes | No |
| Stroke ..... | Yes | No | Sinus Trouble ..... | Yes | No | Fainting or Dizzy Spells ..... | Yes | No |
| Diet (Special/Restricted) ..... | Yes | No | Radiation Therapy ..... | Yes | No | Nervous/Anxious ..... | Yes | No |
| Artificial Joints (hip, knee, etc.) .... | Yes | No | Chemotherapy ..... | Yes | No | Psychiatric/Psychological Care.. | Yes | No |
| Kidney Trouble ..... | Yes | No | Tumors ..... | Yes | No | | | |

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 _____ Months No **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/Guardian Signature _____ Date _____

**History Review**

Dentist Signature _____ Date _____

| Patient Name | |
|---|---|
| Patient Account No. | Medical Alert |

# 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? _____

_____

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.) _____

**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? | (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? _____

**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) |
| Snore or have any other sleeping disorders? | (Yes) | (No) |
| Smoke/chew tobacco or use other tobacco products? | (Yes) | (No) |

**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 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 your teeth's appearance?** | (Yes) | (No) |
| 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 _____

| | | |
|---|---|---|
| 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?** | (Yes) | (No) |

If yes, please describe _____

_____

(Please complete other side)