TIME: DATE:

Patient name: Birth Date:

DENTAL HISTORY

--- PLEASE COMPLETE BOTH PAGES ---

What is the reason for your visit today?

Date of Last Dental Visit? Last Dental Cleaning Last Full Mouth X-rays

When was your last dental visit?

Previous Dentist Name? Phone:

Address: State: Zip:

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 you 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?	Y	N
Sweets?	Y	N
Biting or chewing?	Y	N
Have you noticed any mouth odors or bad taste?	Y	N
Do you frequently get cold sores, blisters or any other oral lesions?	Y	N
Do your gums bleed or hurt?	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 in between your teeth?	Y	N
If yes, where?		

Do you:

Clench or grind your teeth while awake or asleep?	Y	N
Bite your lips or cheeks regularly?	Y	N
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)?	Y	N
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
Smoke/chew tobacco or use other tobacco products?	Y	N

Have you every had:

Orthodontic treatment?	Y	N
Oral surgery?	Y	N
Periodontal treatment?	Y	N
Your teeth ground or the bite adjusted?	Y	N
A bite plate or mouth guard?	Y	N
A serious injury to the mouth or head?	Y	N
If yes, please describe, including cause	Y	N

Have you ever experienced:

Clicking or popping of the jaw?	Y	N
Pain (joint, ear, side of face)?	Y	N
Difficulty in opening or closing the mouth?	Y	N
Difficulty in chewing on either side of the mouth?	Y	N
Headaches, neck aches or shoulder aches?	Y	N
Sore muscles (neck, shoulders)?	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?	Y	N
Have you ever had an upsetting dental experience?	Y	N
If yes, please describe:		

Have you ever been told to take a pre-medication prior to dental treatment? Y N

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

Signature: ______________________________ Date:

TIME: DATE:

Patient name: **MEDICAL HISTORY** Birth Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you may receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes:
Have you ever been hospitalized or had a major operation?	Yes	No	If yes:
Have you ever had a serious head or neck injury?	Yes	No	If yes:
Are you taking any medications, pills, or drugs?	Yes	No	If yes:
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes:
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes:
Are you on a special diet?	Yes	No	If yes:
Do you use tobacco?	Yes	No	If yes:
Do you use controlled substances?	Yes	No	If yes:

Women: Are you…

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other? Please list all:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Y	N	Cortisone Medicine	Y	N	Hemophilia	Y	N	Radiation Treatments	Y	N
Alzheimer's Disease	Y	N	Diabetes	Y	N	Hepatitis A	Y	N	Recent Weight Loss	Y	N
Anaphylaxis	Y	N	Drug Addiction	Y	N	Hepatitis B or C	Y	N	Renal Dialysis	Y	N
Anemia	Y	N	Easily Winded	Y	N	Herpes	Y	N	Rheumatic Fever	Y	N
Angina	Y	N	Emphysema	Y	N	High Blood Pressure	Y	N	Rheumatism	Y	N
Arthritis/Gout	Y	N	Epilepsy or Seizures	Y	N	High Cholesterol	Y	N	Scarlet Fever	Y	N
Artificial Heart Valve	Y	N	Excessive Bleeding	Y	N	Hives or Rash	Y	N	Shingles	Y	N
Artificial Joint	Y	N	Excessive Thirst	Y	N	Hypoglycemia	Y	N	Sickle Cell Disease	Y	N
Asthma	Y	N	Fainting Spells/Dizziness	Y	N	Irregular Heartbeat	Y	N	Sinus Trouble	Y	N
Blood Disease	Y	N	Frequent Cough	Y	N	Kidney Problems	Y	N	Spina Bifida	Y	N
Blood Transfusion	Y	N	Frequent Diarrhea	Y	N	Leukemia	Y	N	Stomach/Intestinal Disease	Y	N
Breathing Problems	Y	N	Frequent Headaches	Y	N	Liver Disease	Y	N	Stroke	Y	N
Bruise Easily	Y	N	Genital Herpes	Y	N	Low Blood Pressure	Y	N	Swelling of Limbs	Y	N
Cancer	Y	N	Glaucoma	Y	N	Lung Disease	Y	N	Thyroid Disease	Y	N
Chemotherapy	Y	N	Hay Fever	Y	N	Mitral Valve Prolapse	Y	N	Tonsillitis	Y	N
Chest Pains	Y	N	Heart Attack/Failure	Y	N	Osteoporosis	Y	N	Tuberculosis	Y	N
Cold Sores/Fever Blisters	Y	N	Heart Murmur	Y	N	Pain in Jaw Joints	Y	N	Tumors or Growths	Y	N
Congenital Heart Disorder	Y	N	Heart Pacemaker	Y	N	Parathyroid Disease	Y	N	Ulcers	Y	N
Convulsions	Y	N	Heart Trouble/Disease	Y	N	Psychiatric Care	Y	N	Venereal Disease	Y	N
Yellow Jaundice	Y	N									

Have you ever had any serious illness not listed above? Y N If yes:

Comments:

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Signature of Patient, Parent or Guardian:

Signature: ______________________________ Date: