

MEDICAL HISTORY

Patient Name _____

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 Pondimin 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

This area is reserved for the dentist's review of the patient's medical history. It is not to be filled out by the patient or guardian.

Dentist Signature _____ Date _____

Patient Name _____

DENTAL HISTORY

Patient Account No. _____

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-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?

- 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)