Patient Name:
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? ______________
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:			**Have you ever had:**	
Hot or cold?	Yes No		Orthodontic treatment?	Yes No
Sweets?	Yes No		Oral surgery?	Yes No
Biting or chewing?	Yes No		Periodontal treatment?	Yes No
Have you noticed any mouth odors or bad tastes?	Yes No		Your teeth ground or the bite adjusted?	Yes No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes No		A serious injury to the mouth or head? If so, please describe, including cause. ______________	Yes No
			A bite plate or mouth guard?	Yes No
Do your gums bleed or hurt?	Yes No			
Have your parents experienced gum disease or tooth loss?	Yes No		**Have you experienced:**	
Have you noticed any loose teeth or change in your bite?	Yes No		Clicking or popping of the jaw?	Yes No
Does food tend to become caught between your teeth? If yes, where? ______________	Yes No		Difficulty in chewing on either side of the mouth?	Yes No
			Difficulty in opening or closing mouth?	Yes No
Do you:			Pain? (joint, ear, side of face)	Yes No
Clench or grind your teeth while awake or asleep?	Yes No		Headaches, neck aches or shoulder aches?	Yes No
Bite your lips or cheeks regularly?	Yes No		Sore muscles (neck, shoulders)?	Yes No
Hold foreign objects with your teeth? (Pencils, pipe, pins, nails, fingernails)	Yes No			
Mouth breathe while awake or asleep?	Yes No		**Are you satisfied with your teeth's appearance?**	Yes No
Have tired jaws, especially in the morning?	Yes No		Would you like to keep all your teeth all your life?	Yes No
Do you feel nervous about having dental treatment? If so, what is your biggest concern? - ______________			Have you ever had an upsetting dental experience? If yes, please describe. ______________	

Is there anything else about having dental treatment that you would like us know? Yes No
If yes, please describe. ____

MEDICAL HISTORY

Patient Name:
Medical Alert:

1. Have you been under the care of a medical doctor during the past two years?-- Yes No
   If yes, for what? ______________________________
   Physicain's Name ______________________ Phone ______________________
   Address ______________________ City ____________ State ____________ Zip ____________
2. Have you taken any medication or drugs during he past two years?-- Yes No
3. Are you taking medications, drugs or pills now?-- Yes No
   If yes, please list name and dosage. ______________________________
4. Are you aware of having an allergic (**or adverse reaction**) to any medication of substance?------------------------------- Yes No
   If yes, please list: ______________________________
5. Have you been a patient in the hospital during the past five years?--- Yes No
6. 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 (infectious) B (serum)--- 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---------------------------------- Yes No
Heart Murmur--------------------- Yes No	Glaucoma-------------------------------- Yes No	H.I.V. Positive--------------------------Yes No
High Blood Pressure--------------Yes No	Contact Lenses------------------------- Yes No	Cold Sores/Fever Blisters-------------Yes No
Mitral Valve Prolapsed-----------Yes No	Emphysema----------------------------- Yes No	Blood Transfusion---------------------- Yes No
Artificial Heart Valve----------- Yes No	Chronic Cough------------------------- Yes No	Hemophilia------------------------------ Yes No
Heart Pacemaker------------------ Yes No	Tuberculosis---------------------------- Yes No	Sickle Cell Disease--------------------- Yes No
Rheumatic Fever------------------ Yes No	Asthma---------------------------------- Yes No	Bruise Easily---------------------------- Yes No
Arthritis/ Rheumatism-----------Yes No	Hay Fever------------------------------- Yes No	Liver Disease---------------------------- Yes No
Cortisone Medicine---------------Yes No	Latex Sensitivity----------------------- Yes No	Yellow Jaundice------------------------ Yes No
Swollen Ankles------------------- Yes No	Allergies or Hives-----------------------Yes No	Neurological Disorders---------------- Yes No
Stroke------------------------------Yes No	Sinus Trouble---------------------------Yes No	Epilepsy or Seizures-------------------- Yes No
Diet (Special/Restricted)---------Yes No	Radiation Therapy--------------------- Yes No	Fainting or Dizzy Spells--------------- Yes No
Artificial Joints (hip, knee, etc)- Yes No	Chemotherapy--------------------------Yes No	Nervous/Anxious----------------------- Yes No
Kidney Trouble------------------- Yes No	Tumors---------------------------------- Yes No	Psychiatric/Psychological Care------- Yes No

7. Do you use more than two pillows to sleep?-- Yes No
8. Have you lost or gained more than 10 pounds in the last year?--- Yes No
9. Do you have or have you had any disease, condition, or problem not listed?-- Yes No
   If yes, please list: ______________________________
10. **Women.** Are you: **Pregnant?** Yes, ____ Months No **Nursing?** Yes No **Taking Birth Control Pills?**-- Yes No
11. Do you smoke or chew tobacco? 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

Doctor Signature ______________________________ Date ____________