# DENTAL HISTORY

*So that we may provide you with the best possible care please complete both side of this medical/dental history form*
***ALL INFORMATION IS COMPLETELY CONFIDENTIAL.***

**Patient Name**_____

**Medical Alert**_____

What is the reason for your visit today? _____
_____

Date of last dental visit _____ Last dental cleaning_____Last full mouth set of x-rays_____

What was done at your last dental visit? _____

Previous dentist's name_____

Dentist's Address_____

Dentist's phone number_____

How often do you have dental examinations?_____
How often do you brush your teeth? _____
How often do you floss your teeth?_____
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 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 object with your teeth (pencils, pipe,
pins, nails, fingernails)?_____ **Yes No**
Mouth breathe while awake or aslppe?_____ **Yes No**
Have tired jaws, especially in the morning?_____ **Yes No**
Smoke or chew tobacco?_____ **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_____Ye s No
A bite plate or mouthguard_____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, neck aches 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 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_____
_____

If there is anything else about having dental treatment you would like us to know, please write it here: _____
_____

**PLEASE COMPLETE OTHER SIDE**

# 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?_____

   Physician's name: _____ Phone_____

   Physician's address:_____ City_____ State_____ Zip_____

2. Have you taken any medication or drugs during the past two years?_____ **Yes No**
3. Are you taking any medication, 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 or substance?___ **Yes No**
   If yes, please explain:_____
5. Have you been a patient in the hospital during the last 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** | 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 Medicine_____ | **Yes** | **No** | Swollen Ankles_____ | **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** |
| Hepatitis A, B or C serum? _____ | **Yes** | **No** | Diabetes?_____ | **Yes** | **No** |
| HIV?_____ | **Yes** | **No** | Headaches?_____ | **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 past 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? If yes, # of months _____. Nursing? Yes No Taking birth control pills? **Yes No**

**Patient/Guardian Signature**_____ **Date**_____

Form revised 4/20/12