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? _____

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
Smoke/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?	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_____

_____

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)

MEDICAL HISTORY FOR

NAME

DATE

PHYSICIAN

NAME

PHONE

LIST ANY RECENT SERIOUS MEDICAL PROBLEMS

1) 3)
2) 4)

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS

CARDIOVASCULAR PROBLEMS CIRCLE YES OR NO

YES	NO	HEART ATTACK DATE _____
YES	NO	ANGINA
YES	NO	BY PASS SURGERY DATE _____
YES	NO	PACEMAKER DATE PLACED _____
YES	NO	HIGH BLOOD PRESSURE

HEART CONDITIONS REQUIRING PREMEDICATION FOR INVASIVE DENTAL PROCEDURES

YES	NO	RHEUMATIC FEVER
YES	NO	MITRAL VALVE PROLAPSE
YES	NO	HEART MURMUR
YES	NO	AORTIC VALVE REPLACEMENT

OTHER CONDITIONS REQUIRING PREMEDICATION

YES	NO	FULL JOINT REPLACEMENT

OTHER _____

TUMORS

YES	NO	BENIGN TUMOR
YES	NO	MALIGNANT TUMOR
YES	NO	RADIATION THERAPY
YES	NO	CHEMOTHERAPY

LIST MEDICATIONS YOU ARE TAKING	FOR

BLEEDING PROBLEMS

YES	NO	TAKING ANTICOAGULANTS
YES	NO	HEMOPHILIA
YES	NO	PROLONGED BLEEDING AFTER A CUT OR SURGERY

UPPER AND LOWER RESPIRATORY SYSTEM

YES	NO	SINUSITIS
YES	NO	TUBERCULOSIS
YES	NO	ASTHMA
YES	NO	EMPHYSEMA
YES	NO	CHRONIC COUGH

LIVER PROBLEMS

YES	NO	HEPATITIS A (INFECTIOUS) B (SERUM)
YES	NO	YELLOW JAUNDICE

NEUROLOGIC DISORDERS

YES	NO	EPILEPSY, CEREBRAL PALSY, M.S.
YES	NO	STROKE
YES	NO	NERVOUS/ANXIOUS
YES	NO	PSYCHIATRIC/PSYCHOLOGICAL CARE
YES	NO	OTHER _____

OTHER DISEASES

YES	NO	DIABETES
YES	NO	GLAUCOMA
YES	NO	VENEREAL DISEASE
YES	NO	A.I.D.S.
YES	NO	H.I.V. POSITIVE

WOMEN

YES	NO	PREGNANT TRIMESTER 1ST 2ND 3RD (CIRCLE)
YES	NO	NURSING

ALLERGIES

YES	NO	PENICILLIN OR OTHER DRUGS
YES	NO	ADVERSE REACTION TO ANY MEDICATION

THE ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE. YOU MAY REQUEST NEEDED INFORMATION FROM MY PHYSICIAN.

PATIENT SIGNATURE _____

Thank you for completing this medical history form. This will help in providing your dental care in a more safe and efficient manner.