Patient Name: _____

DENTAL HISTORY

So that we may provide you with the best possible care, please complete form in its entirety.
All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit ___/___/___ **Last Dental Cleaning**___/___/___ **Last Panoramic/Full Mouth X-ray** ___/___/___

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 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:

Yes No 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?
If so, where? _____

Do you:

Yes No 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?

Have you ever had:

Yes No 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?
If so, please describe, including cause _____
_____

Have you Experienced?

Yes No Click or popping of the jaw?
Yes No Pain? (Joint, ear, side of face)
Yes No Difficulty in opening or closing 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 of your life?
Yes No Do you feel nervous about having dental treatment?
If so, what is your biggest concern? _____
_____

Yes No Have you ever had an upsetting dental experience? 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 _____
_____

Patient/Guardian Signature _____ Date _____

Patient Name: _____

MEDICAL HISTORY

1. Medical Doctor'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. Do you have artificial joints (Knee, hip, etc)..... Yes No
   If yes, date of surgery _____
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ..... Yes No
   Drug: _____ Duration: _____
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.

Yes No.....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	(IE: Dementia, Alzheimer's)
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.....Kidney Trouble	Yes No.....Chemotherapy	Yes No.....Defibrillator
Yes No.....Psychiatric/Psychological Care	Yes No.....Tumors	

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
11. **Women:** Are you pregnant or think you could be pregnant? ....Yes (____ Months) No **Nursing?** ..... Yes No
12. Do you use birth control prescription? ..... 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 _____

Medical Alerts:

Doctor Notes: