

# MEDICAL HISTORY

Patient Name _____	
Patient Account No. _____	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 \_\_\_\_\_  
 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 or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines?..... Yes No  
 If yes, please list name and dosage \_\_\_\_\_
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimin (fenfluramine); and Redux (dexfenfluramine)?..... Yes No  
 If yes to the above, did you have a medical exam for heart issues?..... Yes No
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance?..... Yes No  
 If yes, please list: \_\_\_\_\_
6. Have you been a patient in the hospital during the past five years?..... Yes No
7. 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.....	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 Prolapse.....	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
8. Do you use more than two pillows to sleep?..... 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 may be pregnant? Yes, \_\_\_\_\_ Months No **Nursing?** Yes No
12. **Women:** Do you use birth control medications?..... 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 dentist of any changes in my health or medication.*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## History Review

Dentist Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient Name
Patient Account No.

# DENTAL HISTORY

Medical Alert
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*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  
 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

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 \_\_\_\_\_

**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? \_\_\_\_\_

**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

**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

**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)