

Dental History Form

Patient Name: _____ Patient Account No. _____
Medical Alert: _____

Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.
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: _____ Telephone: _____

Address: _____ State: _____ Zip: _____

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:

Hot or cold? ☐ Yes ☐ No

Sweets? ☐ Yes ☐ No

Biting or chewing? ☐ Yes ☐ No

Have you noticed any mouth odors or bad taste? ☐ 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

Snore or have any other sleeping disorders? ☐ Yes ☐ No

Smoke/chew tobacco or use other tobacco products? ☐ 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 yes, 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 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 _____

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 _____

Medical History Form

Patient Name: _____ Patient Account No. _____
Medical Alert: _____

1. Physician'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 an medication, drugs, pills or herbal remedies, including regular dosages of aspirin? _____ ☐ Yes ☐ No
4. Have you ever taken prescription medications for weight loss (diet pills)? _____ ☐ Yes ☐ No
If yes, did you take any of the following? ☐ Fen-Phen ☐ Pondimen ☐ Redux ☐ Other
If you said yes to any of the above, did you have a medical exam for heart issues? _____ ☐ Yes ☐ No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? _____ ☐ Yes ☐ No
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. Check "Yes" or "No" to each item.

- | | | |
|--|--|---|
| Heart (Surgery, Disease, Attack) _____ ☐ Yes ☐ No | Ulcers _____ ☐ Yes ☐ No | Venereal Disease _____ ☐ Yes ☐ No |
| Chest Pain _____ ☐ Yes ☐ No | Diabetes _____ ☐ Yes ☐ No | AIDS/HIV Positive _____ ☐ Yes ☐ No |
| Congenital Heart Disease _____ ☐ Yes ☐ No | Thyroid Problems _____ ☐ Yes ☐ No | Cold Sores/Fever Blisters _____ ☐ Yes ☐ No |
| Heart Murmur _____ ☐ Yes ☐ No | Glaucoma _____ ☐ Yes ☐ No | Blood Transfusion _____ ☐ Yes ☐ No |
| High/Low Blood Pressure _____ ☐ Yes ☐ No | Contact Lenses _____ ☐ Yes ☐ No | Hemophilia _____ ☐ Yes ☐ No |
| Artificial Heart Valve/Pacemaker _____ ☐ Yes ☐ No | Emphysema _____ ☐ Yes ☐ No | Sickle Cell Disease _____ ☐ Yes ☐ No |
| Rheumatic Fever _____ ☐ Yes ☐ No | Chronic Cough _____ ☐ Yes ☐ No | Bruise Easily _____ ☐ Yes ☐ No |
| Arthritis/Rheumatism _____ ☐ Yes ☐ No | Tuberculosis _____ ☐ Yes ☐ No | Liver Disease/Yellow Jaundice _____ ☐ Yes ☐ No |
| Cortisone Medicine _____ ☐ Yes ☐ No | Asthma _____ ☐ Yes ☐ No | Neurological Disorders _____ ☐ Yes ☐ No |
| Swollen Ankles _____ ☐ Yes ☐ No | Hay Fever/Allergy/Hives _____ ☐ Yes ☐ No | Epilepsy or Seizures _____ ☐ Yes ☐ No |
| Stroke _____ ☐ Yes ☐ No | Latex Sensitivity _____ ☐ Yes ☐ No | Fainting or Dizzy Spells _____ ☐ Yes ☐ No |
| Diet (Special/Restricted) _____ ☐ Yes ☐ No | Sinus Trouble _____ ☐ Yes ☐ No | Nervous/Anxious _____ ☐ Yes ☐ No |
| Artificial Joints (Hip, Knee, etc.) _____ ☐ Yes ☐ No | Radiation Therapy _____ ☐ Yes ☐ No | Psychiatric/Psychological Care _____ ☐ Yes ☐ No |
| Kidney Trouble _____ ☐ Yes ☐ No | Chemotherapy _____ ☐ Yes ☐ No | |
| | Tumors _____ ☐ Yes ☐ No | |
| | Hepatitis A, B, C ☐ A ☐ B ☐ C | |

9. Have you lost or gained more than 10 pounds in the last 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 prescriptions? _____ ☐ Yes ☐ No

I understand the above information in 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

Dentist Signature: _____ Date: _____