

MEDICAL HISTORY

MEDICAL ALERT: _____

For office use only

Welcome! So that we may provide you with the best possible care, please complete both the medical and dental history form. All information is completely confidential.

Patient Name: _____
Patient Address: _____
Best Phone Number to reach you during the day: _____
Alternate Phone Number for evenings or weekends: _____
Email: _____
DOB: _____/_____/_____ Sex: M F

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 medications or drugs in the past two years including over the counter? Yes No
3. Are you taking any medications, drugs or pills including over the counter, herbal and appetite suppressants? Yes No
If yes, please list the name and dosage:

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 (Fenfluramine-Phenopermine) Yes No
Pondimin (Fenfluramine) Yes No
Redux (Dexfenfluramine) Yes No

If yes to any of 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
If yes why? _____

7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" for each item.

Heart (Surgery, Disease, Attack)	Yes No	Chest Pain	Yes No
*Congenital Heart Disease	Yes No	*Heart Murmur	Yes No
*Mitral Valve Prolapse	Yes No	*Artificial Heart Valve	Yes No
High Blood Pressure	Yes No	Low Blood Pressure	Yes No
Heart Pacemaker	Yes No	Rheumatic Fever	Yes No
Arthritis/Rheumatism	Yes No	Thyroid Problems	Yes No
Cortisone meds or Corticosteroids	Yes No	Swollen Ankles	Yes No
Stroke	Yes No	*Artificial Joints	Yes No
Ulcers	Yes No	Diabetes	Yes No
Glaucoma	Yes No	Contact Lenses	Yes No
Emphysema	Yes No	Chronic Cough	Yes No
Tuberculosis	Yes No	Sinus Trouble	Yes No
Asthma	Yes No	Hay Fever	Yes No
Allergies or Hives	Yes No	Latex Sensitivity	Yes No
Tumors	Yes No	Cancer	Yes No
Radiation Therapy	Yes No	Chemotherapy	Yes No

Hepatitis A (infectious)	Yes No	Hepatitis B or C (serum)	Yes No
Venereal Disease	Yes No	H.I.V. Positive	Yes No
A.I.D.S	Yes No	Cold Sores/Fever Blisters	Yes No
Blood Transfusion	Yes No	Hemophilia	Yes No
Sickle Cell Disease	Yes No	Bruise Easily	Yes No
Kidney Trouble	Yes No	Liver Disease	Yes No
Yellow Jaundice	Yes No	Neurological Disorders	Yes No
Epilepsy or Seizures	Yes No	Fainting or Dizzy Spells	Yes No
Diet (Special/Restricted)	Yes No	Alcohol use (frequency)	_____
Tobacco use (frequency)	_____	Caffeine use (frequency)	_____
Nervous/Anxious	Yes No	Psychiatric/Psychological Care	Yes No

8. *If you answered "yes" to congenital heart disease, heart murmur, mitral valve prolapse, artificial heart valve, or artificial joints, do you require pre-medication with an antibiotic before dental treatment? Yes No

9. Do you experience migraine, tension or sinus headaches? Yes No

If yes, what is the frequency? _____

Duration? _____

Does either prescription or over the counter medication help with the pain? Yes No

Do you carry Tylenol or Advil in your purse/briefcase? Yes No

10. Do you use more than two pillows to sleep? Yes No

11. Have you gained or lost more than 10 pounds in the past year? Yes No

12. Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list:

12. **Women** Are you: **Pregnant?** Yes ____ months No **Nursing?** Yes No

Taking birth control pills? 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 in the future.

Patient/Guardian Signature _____ Date _____

History Review

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DENTAL HISTORY

Patient Name: _____ Date: _____

What is the reason for your visit today? _____

Date of last dental visit: _____ Date of last dental cleaning: _____

Date of last full mouth x-ray series: _____ (18 different pictures)

What was done at your last dental visit?

Previous dentist's name: _____ Address: _____

Previous dentist's phone: _____

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? (Sonicare, fluoride rinse, floss threader, 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
 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 ever had:

Orthodontic treatment Yes No
 Oral surgery Yes No
 Scaling & root planing Yes No
 Gum surgery Yes No
 Your bite adjusted Yes No
 A bite plate or mouthguard Yes No
 Serious injury to your mouth or head Yes No
 If yes, please describe, including cause & date of accident _____

Do you:

Clench or grind your teeth while awake or asleep? Yes No
 Bite your lips or cheeks regularly? Yes No
 Chew on pencils, pipe, pens nails, fingernails? Yes No

Have you experienced:

Clicking or popping of your jaw Yes No
 Pain (joint, ear, side of face) Yes No
 Difficulty in opening or closing your mouth Yes No
 Headaches, neck or shoulder pain Yes No
 Sore muscles (neck, shoulders) Yes No

How often do you:

Have tired jaws, especially in the morning?	Never	Sometimes	Frequently	Always
After a full night's sleep (at least 6 hours), how rested do you feel? (not rested at all) 1 2 3 4 5 6 7 8 9 10 (fully rested)				
Snore while sleeping?	Never	Sometimes	Frequently	Always
Feel sleepy during the day?	Never	Sometimes	Frequently	Always
Have heartburn or gastric reflux?	Never	Sometimes	Frequently	Always
Wake up at night and have trouble falling back to sleep?	Never	Sometimes	Frequently	Always
Wake up early and can't go back to sleep?	Never	Sometimes	Frequently	Always
Experience uncomfortable and/or restless sensations in your legs at night?	Never	Sometimes	Frequently	Always
Notice your legs moving or jerking at night?	Never	Sometimes	Frequently	Always
Wake up gasping for breath?	Never	Sometimes	Frequently	Always
Fall asleep while driving?	Never	Sometimes	Frequently	Always

Are you satisfied with your teeth's appearance? Yes No

If no, what would you like to change about your smile? _____

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 yes, 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
