MEDICAL HISTORY

Patient Name
Medical Alert

1. Physician's Name_____ Phone _____
   Address_____ City_____ State_____ Zip _____
2. Are you taking any medication, drugs or pills now ..... Yes No
   If yes, please list name and dosage:_____
3. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes No
   If yes, please list: _____
4. 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	Swollen Ankles ..... Yes No	Chemotherapy ..... Yes No
Chest Pain ..... Yes No	Stroke ..... Yes No	Cancer Therapy ..... Yes No
Congenital Heart Disease ..... Yes No	Artificial Joints (hip, knee, etc.) ..... Yes No	Tumors ..... Yes No
Endocarditis History ..... Yes No	Back problems ..... Yes No	History of Drug/Alcohol Abuse ..... Yes No
Heart Murmur/Mitral Valve ..... Yes No	Kidney Trouble ..... Yes No	Smoke/Chew Tobacco ..... Yes No
High Blood Pressure ..... Yes No	Ulcers ..... Yes No	Venereal Disease ..... Yes No
Blood Thinners ..... Yes No	Thyroid Problems ..... Yes No	A.I.D.S. /H.I.V. Positive ..... Yes No
Artificial Heart Valve ..... Yes No	Glaucoma ..... Yes No	Cold Sores/Fever Blisters ..... Yes No
Heart Pacemaker ..... Yes No	Emphysema ..... Yes No	Blood Transfusion ..... Yes No
Diabetes ..... Yes No	Chronic Cough ..... Yes No	Hemophilia ..... Yes No
Hepatitis A,B, or C ..... Yes No	Dry Mouth ..... Yes No	Sickle Cell Disease ..... Yes No
Tuberculosis ..... Yes No	Asthma ..... Yes No	Neurological Disorders ..... Yes No
Rheumatic Fever ..... Yes No	Hay Fever ..... Yes No	Epilepsy or Seizures ..... Yes No
Organ Transplant ..... Yes No	Latex Sensitivity ..... Yes No	Fainting or Dizzy Spells ..... Yes No
Osteoporosis Medicine/Treatment .. Yes No	Sinus Trouble ..... Yes No	Psychiatric/Psychological Care ..... Yes No
Arthritis ..... Yes No	Radiation Therapy ..... Yes No	Anorexia/Bulimia ..... Yes No

5. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
6. **Women.** Are you: **Pregnant?** Yes, ___ Months 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 may have the permission to ask the respective health care provider or agency, whom 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

Date: _____

Date: _____

Date: _____

Date: _____

Doctor Signature: _____ Date: _____

Patient Name

DENTAL HISTORY

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, Cold or Sweets? Yes No
Biting or chewing on either side of the mouth? Yes No
Have you noticed any mouth odors or bad taste? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experience gum disease or tooth loss? Yes No
Have you notice any loose teeth or change in your bite? Yes No

Do you:

Clench or grind your teeth when you are asleep or awake? Yes No
Hold foreign objects with your teeth? Yes No
(pencils, pipe, pins, nails, fingernails)
Have tired jaws especially in the morning? Yes No

Have you ever had:

Orthodontic treatment? Yes No
Oral Surgery? Yes No
Periodontal treatment? 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 in the jaw? Yes No
Pain? (joint, ear, side of face) Yes No

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

Do you wish your teeth were whiter? Yes No

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: _____

_____

_____

_____