DENTAL HISTORY

What is the reason for your visit today?_____

Date of last dental visit_____ Last dental cleaning_____ Last full mouth X-Rays_____

Previous dentist's name _____ 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 currently using topical fluoride? .....❒Yes ❒No

What other dental aids do you use? (Waterpik, toothpick, etc.) _____

Do you have any dental problems now? ❒Yes ❒No If yes, please describe_____

_____

Check any of the following which apply in either past or present:

- ❒ Hot or Cold Sensitivity
- ❒ Sweets Sensitivity
- ❒ Biting or Chewing Sensitivity
- ❒ Experience bad odors or bad tastes
- ❒ Frequent cold sores, blisters or other lesions
- ❒ Bleeding gums
- ❒ Painful gums
- ❒ Experienced gum disease
- ❒ Have tooth loss
- ❒ Loose teeth
- ❒ Change in your bite
- ❒ Food catches between your teeth
- ❒ Clench or grind teeth while asleep
- ❒ Clench or grind teeth while awake
- ❒ Bite lips or cheek regularly
- ❒ Hold foreign objects with teeth (i.e. pencil)
- ❒ Mouth breathe while awake or asleep
- ❒ Snore or other sleeping disorders
- ❒ Use, smoke, chew tobacco
- ❒ Orthodontic treatment
- ❒ Oral Surgery
- ❒ Periodontal treatment
- ❒ Your teeth ground or bite adjusted
- ❒ Received a bite plate or mouth guard
- ❒ Clicking or popping of jaw
- ❒ Pain (joint, ear, side of face)
- ❒ Difficulty opening / closing mouth
- ❒ Difficulty chewing on either side of mouth
- ❒ Head, neck, or shoulder aches
- ❒ Sore muscles (neck, shoulder)
- ❒ A serious injury to the mouth or head?
  If so, please describe, including cause_____
  _____
- ❒ Experience tired jaws, especially in the morning

2. Are you satisfied with your teeth's appearance?.....❒Yes ❒No
3. Would you like to keep all of your teeth all of your life? .....❒Yes ❒No
4. Do you feel nervous about dental treatment? .....❒Yes ❒No

   If so, what is your biggest concern? _____
5. Have you ever had an upsetting dental experience? .....❒Yes ❒No

   Please describe_____
6. Have you ever been told to take a pre-medication prior to dental treatment? .....❒Yes ❒No
7. Is there anything else you would like us to know? Please describe :

_____

_____

_____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?……..❒Yes ❒No
   If yes: for what reason _____
2. Physician name and phone number_____
3. Have you been a patient in the hospital during the past five years?……..……...❒Yes ❒No
   If yes: for what reason?_____
4. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ❒Yes ❒No If yes, please list:_____
5. Have you taken any medicine or drugs during the past two years? ❒Yes ❒No If yes, please list:

   _____
6. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?
   ❒Yes ❒No If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux
   If yes to any of the above, did you have a medical exam for heart issues? …… ❒Yes ❒No
7. Are you aware of having an allergic (or adverse) reaction to any substance or medication?…… ❒Yes ❒No
   If yes, please explain:_____
8. Check any of the following which apply in either past or present:

❒Heart (Surgery, Disease, Attack)	❒ Latex Sensitivity	❒ Tumors
❒ Chest Pain	❒ Ulcers	❒ Hepatitis A B C (circle)
❒ Congenital Heart Disease	❒ Kidney Trouble	❒ Venereal Disease
❒ Heart Murmur	❒ Diabetes	❒ A.I.D.S./H.I.V. Positive
❒ High/Low Blood Pressure	❒ Thyroid Problems	❒ Cold Sores / Fever Blisters
❒ Mitral Valve Prolapse	❒ Glaucoma	❒ Blood Transfusion
❒ Artificial Heart Valve / Pacemaker	❒ Contact Lenses	❒ Hemophilia
❒ Artificial Joints (hip, knee, etc.)	❒ Emphysema	❒ Sickle Cell Disease
❒ Bleeding Problems	❒ Chronic Cough	❒ Bruise Easily
❒ Rheumatic Fever	❒ Tuberculosis	❒ Liver Disease / Yellow Jaundice
❒ Arthritis/Rheumatism	❒ Asthma	❒ Neurological Disorders
❒ Cortisone Medicine	❒ Hay Fever / Allergies / Hives	❒ Epilepsy or Seizures
❒ Swollen Ankles	❒ Sinus Trouble	❒ Fainting or Dizzy Spells
❒ Stroke	❒ Radiation Therapy	❒ Nervous / Anxious
❒ Diet (Special / Restricted)	❒ Chemotherapy	❒ Psychiatric / Psychological Care

Do you have any disease, condition or problem not listed? If so, please list_____

Women: Are you pregnant or think you could be pregnant? Yes Months ____ No Nursing? ❒Yes ❒No

Do you use birth control prescriptions?……..❒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_____