PATIENT MEDICAL HISTORY

Patient's Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	Yes	No
1. Are you in good health?	☐	☐
2. Have there been any changes in your general health within the past year? _____	☐	☐
3. Date of your last physical exam: _____		
4. Physicians name: _____ Address:_____ Phone: _____		
5. Are you now under the care of a physician?	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain: _____ _____	☐	☐
7. Are you taking any medicine(s)?	☐	☐
Including non-prescription medicine?	☐	☐
If yes, what (include herbs & vitamins) _____ _____		
8. Are you on any special diet?	☐	☐
If yes, what kind? _____		
9. Have you ever been rejected to donate blood?	☐	☐
Have you been tested for tuberculosis? _____	☐	☐
Have you been vaccinated? _____	☐	☐
What kind?_____		

	Yes	No
10. Do you bruise easily? _____	☐	☐
11. Have you ever required a blood transfusion?____	☐	☐
12. Have you had a recent weight loss?_____	☐	☐
13. Have you ever taken Fen-Phen / Redux?_____	☐	☐
14. Do you use tobacco? What kind and how much _____	☐	☐
15. Do you/have you used controlled substances?	☐	☐
16. Are you wearing contact lenses?_____	☐	☐
17. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?_____	☐	☐
18. Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐
If yes, what _____		
WOMEN ONLY:		
Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

Are you allergic to or have you had reactions to:	Yes	No
Local Anesthetics like Novocaine_____	☐	☐
Penicillin or Other Antibiotics_____	☐	☐
Sulfa Drugs _____	☐	☐
Barbiturates, Sedatives or Sleeping Pills _____	☐	☐
Aspirin _____	☐	☐
Iodine _____	☐	☐
Any Metals (e.g. Nickel, Mercury, etc.)_____	☐	☐
Latex / Rubber _____	☐	☐
Other (please list)_____		
Do you have or have you ever had the following:		
Rheumatic Heart Disease or Rheumatic Fever	☐	☐
Scarlet Fever _____	☐	☐
Heart Defect or Heart Murmur _____	☐	☐
Heart Trouble, Heat Attack, or Angina _____	☐	☐
Chest Pain _____	☐	☐
Shortness of Breath _____	☐	☐
Pacemaker _____	☐	☐
Heart Surgery _____	☐	☐
High/Low Blood Pressure _____	☐	☐
Congenital Heart Problems _____	☐	☐
Swelling of Feet, Ankles, Hands _____	☐	☐
Hepatitis, Jaundice or Liver Disease _____	☐	☐
Stroke _____	☐	☐
Sinus Problems _____	☐	☐
Lung or Breathing Problems _____	☐	☐
Asthma or Hay Fever _____	☐	☐
Hives or Skin Rash _____	☐	☐

	Yes	No
Fainting or Dizzy Spells _____	☐	☐
Diabetes _____	☐	☐
AIDS or HIV Infection _____	☐	☐
Thyroid Problems _____	☐	☐
Allergies _____	☐	☐
Arthritis or Rheumatism _____	☐	☐
Joint replacement or Implant _____	☐	☐
Stomach Ulcer _____	☐	☐
Kidney Trouble _____	☐	☐
Tuberculosis _____	☐	☐
Persistent Cough _____	☐	☐
Chemotherapy (Cancer/ Leukemia) _____	☐	☐
Sexually Transmitted Disease _____	☐	☐
Epilepsy or Seizures _____	☐	☐
Anemia _____	☐	☐
Glaucoma _____	☐	☐
Nervousness _____	☐	☐
Tonsillitis _____	☐	☐
Tumors _____	☐	☐
Mental Health Care _____	☐	☐
Back Problems _____	☐	☐
Chemical Dependency _____	☐	☐
Mitral Valve Prolapse _____	☐	☐
Cortisone Treatment _____	☐	☐
Cold Sore / Fever Blisters _____	☐	☐
Hypoglycemia _____	☐	☐
Eating Disorders _____	☐	☐

PATIENT DENTAL HISTORY

Patient's Name: _____ Date of Birth: _____

Reason for visit_____

When was your last dental visit?_____ What was done at that time?_____

How often did you visit before then? _____

Previous dentist (name and location) _____

Have you had a complete series of dental films (x-rays) taken? When_____ Where_____

How often do you brush your teeth?_____ How often do you floss your teeth? _____

Is your drinking water fluoridated or fluoride product at home? _____

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing? _____	☐	☐	Does food tend to become caught between your teeth?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods? _____	☐	☐	Have you ever had periodontal treatment (gums)?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods? _____	☐	☐	Ever worn a bite plate or other appliance? _____	☐	☐
Do you feel pain to any of your teeth? _____	☐	☐	Ever had any abnormal bleeding after extraction? _____	☐	☐
Do you have any sores or lumps in or near your mouth? _____	☐	☐	Do you wear dentures or partials?_____	☐	☐
Have you had neck, head, or jaw injuries? _____	☐	☐	If yes, date of placement _____		
Have you ever experienced any of the following problems in your jaw?			Have you ever received oral hygiene instructions regarding		
Clicking _____	☐	☐	the care of your teeth and gums?_____	☐	☐
Pain (joint, ear, side of face) _____	☐	☐	Do you have any oral piercing? _____	☐	☐
Difficulty in opening or closing _____	☐	☐	Do you have any oral habits? _____	☐	☐
Difficulty in chewing _____	☐	☐	Are you nervous about dental treatment? _____	☐	☐
Doyou havefrequent headaches,neck pain,upper shoulder pain?	☐	☐	What aids do you use for oral care?		
Do you clench or grind? _____	☐	☐	Manual toothbrush	☐	☐
Have you ever had orthodontic treatment? _____	☐	☐	Electric toothbrush	☐	☐
Do you bite your lips or cheeks frequently? _____	☐	☐			
Have you noticed any loosening of your teeth?_____	☐	☐	Rate your Oral Health ☐Good ☐Fair		☐Poor

If you could change anything about your smile, what would you change?_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the periods of such dental care to third party payers and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date _____

CLINICIANS COMMENTS/UPDATES:

_____

SIGNITURE DATE

Dental History