PATIENT NAME	
PATIENT ACCOUNT NO.	MEDICAL ALERT

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 confidental.

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? _____

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 notice any mouth odors or bad tastes	Yes	No
Do you frequently get cold sores, blisters or	Yes	No
any other oral lesions?	Yes	No

Do your gums bleed or hurt?

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
Smoke/chew tobacco?	Yes	No

Concerning oral hygiene:

How often do you brush your teeth?
____ times per day. When? _____

Do you use a hard, medium or soft bristle brush? Which? _____

Do you use dental floss, rubbertip or Stimudents? Which? _____

Do you use anything else to clean your teeth? If so what? _____

Have you ever had oral hygiene instructions? Yes No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment? When_____	Yes	No
Vincents disease or Trench mouth?	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 so, 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, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with the appearance of your teeth?

Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervouse about having dental treatment?	Yes	No
If so, what is your biggest concern?	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 _____

_____

_____

(Please complete other side)

PATIENT NAME	
PATIENT ACCOUNT NO.	MEDICAL ALERT

MEDICAL HISTORY

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 _____
Have you taken any medication or drugs during the past two years ..... Yes No
Are you taking any medication, drugs or pills now? ..... Yes No
If yes, please list name and dosage _____
Are you aware of having an allergic (or adverse reaction) to any medication or substance? ..... Yes No
If yes, please list: _____
Have you been a patient in the hospital during the past five years? ..... Yes No
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	Ulcers	Yes	No	Hepatitis A (infectious), B (serum), C	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congential Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artifical Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone or Steriods	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Orthopedic Pins	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No
Kidney Trouble	Yes	No						

Do you use more than two pillows to sleep? ..... Yes No
Have you lost or gained more than 10 pounds in the past year? ..... Yes No
Do you have or have you had any diesase, condition, or problem not listed? ..... Yes No
If yes, please list: _____
Women. Are you: Pregnant? Yes,____ Months No Nursing? Yes No Taking birth control pills? Yes No
Have you undergone or are you undergoing menopause? 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 doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____