MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain. _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

DENTAL HISTORY

PATIENT NAME _____ **BIRTH DATE** _____

Are you currently experiencing any dental discomfort? ☐ YES ☐ NO

If YES, please explain _____

Previous Dentist's Name _____ **Phone Number** _____

Date of last dental cleaning _____

Date of last dental x-rays _____

Please check YES or NO if you have had problems with any of the following and location when indicated:

Bad Breath	☐ YES	☐ NO				
Bleeding Gums	☐ YES	☐ NO				
Clicking or popping jaw	YES ☐	NO ☐				
Sensitivity to sweets	YES ☐	NO ☐	Top ☐	Bottom ☐	Left ☐	Right ☐
Wears partials or dentures	YES ☐	NO ☐	Top ☐	Bottom ☐		
Frequent headaches	YES ☐	NO ☐				
Grinding or clenching	☐ YES	☐ NO				
Loose teeth or broken fillings	☐ YES	☐ NO	Top ☐	Bottom ☐	Left ☐	Right ☐
Sores or lumps in mouth	☐ YES	☐ NO	Top ☐	Bottom ☐	Left ☐	Right ☐
Bleeding during brushing/flossing	☐ YES	☐ NO				
Periodontal treatment	☐ YES	☐ NO				
Sensitivity to cold	☐ YES	☐ NO	Top ☐	Bottom ☐	Left ☐	Right ☐
Sensitivity to hot	☐ YES	☐ NO	Top ☐	Bottom ☐	Left ☐	Right ☐
Sensitivity when biting	☐ YES	☐ NO	Top ☐	Bottom ☐	Left ☐	Right ☐
Previous orthodontic treatment	☐ YES	☐ NO				

Is there anything you would like to change to enhance your smile? YES ☐ NO ☐

If YES, please explain: _____

_____

_____

_____

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SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____