Patient Name _____

MEDICAL HISTORY

1. Physician's Name _____ Phone ( ) _____ Medical Number _____

2. Have you had any medical care within the past two years? ……. Yes No
   If yes, for what? _____

3. Have you taken any medication or drug during the past two years?……..…….……Yes No

4. Are you taking any medications, including any "over the counter", i.e aspirin, vitamins, herbs, etc.?…...……. Yes No
   If yes, please list name and dosage _____

5. Have you ever taken prescription medications for weight loss (diet pills)?……..……..Yes No
   If yes, did you take any of the following? (circle if yes) Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues?……..…….. Yes. No

6. Are you aware of having an allergic (or adverse) reaction to any medication or substance?……..…….. .Yes No
   If yes, please list: _____

7. Have you been a patient in the hospital during the past five years?…….…….. Yes No

8. 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)….Yes No
Chest Pain……...Yes No	Diabetes…….…..…Yes No	Venereal Disease…….…….....…Yes No
Congenital 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 or Low Blood Pressure…..…Yes No	Contact Lenses…...Yes No	Cold Sore/Fever Blisters…….…...Yes No
Mitral Valve Prolapse…….Yes No	Emphysema…….....Yes No	Blood Transfusion…….…….....…Yes No
Artificial 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 Medicine…….Yes No	Latex Allergy…..…..Yes No	Yellow Jaundice…….…..…....Yes No
Swollen Ankles……...…Yes No	Allergies/ Hives…...Yes No	Neurological Disorders…….....Yes No
Stroke……..Yes No	Sinus Trouble…..…..Yes No	Epilepsy or Seizure……..…..…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
Kidney Trouble……...Yes No	Tumors……Yes No	Psychiatric/Psychological Care. ..….. Yes No

9. Do you use more than two pillows to sleep?…….…….…….…….…. Yes No

10. Have you lost or gained more than 10 pounds in the past year?……..……..…..Yes No

11. Do you have or have you had any disease, condition, or problem not listed?……..……..……..….Yes No
    If yes, please list: _____

12. **Women:** Are you pregnant or think you could be pregnant? Yes ___Months No Planning on getting pregnant? Yes No

    Nursing? Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a save 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 changes in my heath or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature_____Date_____

(Please complete the other side)

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 _____ Telephone _____

Address_____State_____Zip_____

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? (Waterpik, Sonicare, toothpick, etc.) _____
Have you ever used or are currently using topical fluoride? Yes No

Do you have any dental problems now? Yes No
If yes, please describe: _____

Are your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parent's 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? _____

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	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 mouth?	Yes	No
Headaches, neck aches, or shoulder pain?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you happy with the way your teeth look? Yes No
If not, what would you change? _____
_____ _____

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?	Yes	No
(pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

If yes, how much _____

If we could offer you a simple, inexpensive way to whiten your teeth, would you be interested? Yes No
Planning to keep your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern?
_____

Have you ever had an upsetting dental experience? Yes No
If yes, please describe _____
_____

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe _____
_____