

# DENTAL HISTORY FORM

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? \_\_\_\_\_

Have you ever used or are you currently using topical fluoride?  Yes  No

What other dental aids do you use (Interplak, toothpick, etc.)? \_\_\_\_\_

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 noticed any mouth odors  
or bad taste? .....  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 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
- Snore or have any other sleeping disorders? .....  Yes  No
- Smoke/chew tobacco or use other  
tobacco products? .....  Yes  No

**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 yes, 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, neck aches or shoulder aches? .....  Yes  No
- Sore muscles (neck, shoulders)? .....  Yes  No
- Are you satisfied with your  
teeth's appearance? .....  Yes  No
- Would you like to keep all of 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 \_\_\_\_\_

Patient Name \_\_\_\_\_

# MEDICAL HISTORY

Patient Account No. \_\_\_\_\_

Medical Alert

1. Physician's Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Have you had any medical care within the past two years? .....  Yes  No  
 Describe \_\_\_\_\_
2. Have you taken any medication or drugs during the past two years? .....  Yes  No
3. Are you currently taking an medication, drugs, pills or herbal remedies, including regular dosages of aspirin? .....  Yes  No
4. Have you ever taken prescription medications for weight loss (diet pills)? .....  Yes  No  
 If yes, did you take any of the following? (Check if yes)  Fen-Phen  Pondimin  Redux  Other  
 If yes to any of the above, did you have a medical exam for heart issues? .....  Yes  No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? .....  Yes  No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? .....  Yes  No  
 If yes, please specify \_\_\_\_\_
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. Check "Yes" or "No" to each item.
- |                                                                                                      |                                                                                                       |                                                                                                  |
|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Heart (Surgery, Disease, Attack) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No      | Kidney Trouble ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         | Venereal Disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                  |
| Chest Pain ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | Ulcers ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                 | AIDS/HIV Positive ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                 |
| Congenital Heart Disease .. <input type="checkbox"/> Yes <input type="checkbox"/> No                 | Diabetes ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                               | Cold Sores/Fever Blisters ... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Heart Murmur ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                          | Thyroid Problems ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       | Blood Transfusion ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                 |
| High/Low Blood Pressure .. <input type="checkbox"/> Yes <input type="checkbox"/> No                  | Glaucoma ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                               | Hemophilia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                        |
| Mitral Valve Prolapse ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                 | Contact Lenses ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         | Sickle Cell Disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| Artificial Heart Valve/<br>Pacemaker ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | Emphysema ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                              | Bruise Easily ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                     |
| Rheumatic Fever ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       | Chronic Cough ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                          | Liver Disease/Yellow<br>Jaundice ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Arthritis/Rheumatism ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                  | Tuberculosis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                           | Neurological Disorders .... <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Cortisone Medicine ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                    | Asthma ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                 | Epilepsy or Seizures ..... <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Swollen Ankles..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         | Hay Fever/Allergy/Hives ... <input type="checkbox"/> Yes <input type="checkbox"/> No                  | Fainting or Dizzy Spells .... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Stroke ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                | Latex Sensitivity ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                      | Nervous/Anxious ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   |
| Diet (Special/Restricted) ... <input type="checkbox"/> Yes <input type="checkbox"/> No               | Sinus Trouble ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                          | Psychiatric/Psychological<br>Care ..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints<br>(Hip, Knee, etc.)..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                      |                                                                                                  |
|                                                                                                      | Chemotherapy ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                           |                                                                                                  |
|                                                                                                      | Tumors ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                 |                                                                                                  |
|                                                                                                      | Hepatitis A, B, C .. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C |                                                                                                  |
9. Have you lost or gained more than 10 pounds in the last year? .....  Yes  No
10. Do you have or have you had any disease, condition, or problem not listed? .....  Yes  No
11. Women: Are you pregnant or think you could be pregnant?  Yes \_\_\_ Months  No Nursing?  Yes  No
12. Do you use birth control prescriptions? .....  Yes  No

I understand the above information in 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 \_\_\_\_\_

History Review

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_