MEDICAL HISTORY

Patient Name	Medical Alert

1. 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_____

2. Have you taken any medication or drugs during the past two years? . ..... Yes No

3. Are you taking any medication, drugs or pills now? ..... Yes No

If yes, please list each

Name	Name	Name	Name	Name	Name
Milligram	Milligram	Milligram	Milligram	Milligram	Milligram
Dosage	Dosage	Dosage	Dosage	Dosage	Dosage

4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes No

If yes, please list:_____

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

6. 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
Congenital Heart Disease .....Yes No	Thyroid Problems .....Yes No	A.I.D.S . .....Yes No
Heart Murmur .....Yes No	Glaucoma .....Yes No	HIV. 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
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 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
Kidney Trouble .....Yes No	Tumors .....Yes No	Psychiatric/Psychological Care ..Yes No
Osteoporosis .....Yes No	Blood Disorders .....Yes No	

7. Do you use more than two **pillows** to sleep? ..... Yes No

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

9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No

If yes, please list:_____

10. **Women.** Are you: **Pregnant?** Yes,_____Months 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 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. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes.

Patient/Guardian Signature_____ Date_____

History Review

Doctor Signature: _____ Date _____

DENTAL HISTORY

Patient Name	Medical Alert

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_____

Address_____State_____ Zip_____

Telephone_____

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? (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 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 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

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
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 your teeth's appearance? Yes No
Would you like to keep all of your teeth all of your life? Yes No
Would you like whiter teeth? 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_____

_____

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)