Patient Name		DENTAL HISTORY
Patient Date of Birth	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.

Date of Last Dental Visit	Las	t Den	tal Cleani	ng Last Full Mouth X.rays		
Nhat was done at your last dental visit						
Previous Dentists Name						
Telephone						
How often do you have dental examinations?						
How often do you brush your teeth?				How often do you floss?		
	Yes					
f yes, please describe:						
Are any of your teeth sensitive	e to:			Have you ever had:		
Hot or co	old?	Yes	No	Orthodontic treatment?	Yes	No
Swe		Yes	No	Oral surgery?	Yes	No
Biting or Chewi	_	Yes	No	Periodontal treatment?	Yes	No
Have you noticed any mouth odors or bad tas		Yes	No	Your teeth ground or the bite adjusted?	Yes	No
Do you frequently get cold sores, blister		.,		A bite plate or mouth guard?	Yes	No
any other oral lesic	ns?	Yes	No	A serious injury to the mouth or head?  If so, please describe, including cause	Yes	No
Do your gums bleed or h	urt?	Yes	No	ii 30, piease describe, including cause		
Have your parents experienced gum dise						
or tooth lo		Yes	No	Have you experienced:		
Have you noticed any loose teeth or cha	nge			Clicking or popping of the jaw?	Yes	No
in your b	oite?	Yes	No	Pain? (joint, ear, side of face)	Yes	No
Does food tend to become caught in betw	een			Difficulty in opening or closing the mouth?	Yes	No
your tee	eth?	Yes	No	Difficulty in chewing on either side of the mouth?	Yes	No
If yes, where?				Headaches, neckaches or shoulder aches?	Yes	No
				Sore muscles (neck, shoulders)?	Yes	No
Do y	ou:			Are you satisfied with your teeth's appearance?	Yes	No
Clench or grind your teeth while awake or asle	ep?	Yes	No	Would you like to keep all of your teeth all of your life?	Yes	No
Bite your lips or cheeks regula	arly?	Yes	No			
Hold foreign objects with your tee	eth?			Do you feel nervous about having dental treatment?	Yes	No
(pencils, pipe. pins, nails, fingern	ails)	Yes	No	If so, what is your biggest concern?		
Mouth breathe while awake or asle	-	Yes	No			
Have tired jaws. especially in the morni		Yes	No	Have you ever had an upsetting dental experience?	Yes	No
Smoke/chew tabac	co?	Yes	No	If yes, please describe		

Chest Pain Yes No Diabetes Yes No Venereal Disease Congenital Heart Disease Yes No Thyroid Problems Yes No A.I.D.S	Yes Yes Yes	es Mes MNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNN
If yes, for what? Physician's Name Address City State Zi  2. Have you taken any medication or drugs during the past two years?  3. Are you taking any medication, drugs or pills now? If yes, please list name and dosage 4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? If yes, please list:  5. Have you been a patient in the hospital during the past five years?  6. Indicate which of the following you have had, or have at present. Circle "yes' or "no" to each it  Heart (Surgery, Disease, Attack) Yes No Ulcers	Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes	es Mes MNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNN
If yes, for what? Physician's Name Phone Address City State Zi 2. Have you taken any medication or drugs during the past two years?  3. Are you taking any medication, drugs or pills now? If yes, please list name and dosage 4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? If yes, please list:  5. Have you been a patient in the hospital during the past five years?  6. Indicate which of the following you have had, or have at present. Circle "yes' or "no" to each it  Heart (Surgery, Disease, Attack) Yes No Ulcers	Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes	es Mes MNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNN
Physician's Name	Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes	es M N N N N N N N N N N N N N N N N N N N
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If yes, please list name and dosage  4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? If yes, please list:  5. Have you been a patient in the hospital during the past five years?	Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes	es M N N N N N N N N N N N N N N N N N N N
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If yes, please list:    Have you been a patient in the hospital during the past five years?	Yes  Tem.  Tious) B (serum)Yes  Yes  Yes  Yes  Yes  Yes  Yes  Y	es N N N N N N N N N N
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6. Indicate which of the following you have had, or have at present. Circle "yes' or "no" to each it Heart (Surgery, Disease, Attack) Yes No Ulcers	tem.  tious) B (serum)Yes  Yes  Yes  Yes  Blisters	N N N N N N N N N
Chest Pain Yes No Diabetes Yes No Venereal Disease Congenital Heart Disease Yes No Thyroid Problems Yes No A.I.D.S	Yes           Yes           Yes           Yes           Blisters         Yes           Yes	N N N N N N N N
Chest Pain Yes No Diabetes Yes No Venereal Disease Congenital Heart Disease Yes No Thyroid Problems Yes No A.I.D.S	Yes           Yes           Yes           Yes           Blisters         Yes           Yes	N N N N N N N N
Congenital Heart Disease Yes No Thyroid Problems Yes No A.I.D.S	Yes Yes Yes Se Histers Yes N Yes	N N N N N N N
Heart Murmur	Yes           Blisters         Yes           Nes         Yes           Yes         Yes	N N N N N N N
High Blood Pressure	Blisters       Yes         n       Yes         yes       Yes         se       Yes         Yes       Yes         yes       Yes         orders       Yes         yes       Yes         yes       Yes	N N N N N N
Mitrai Valve Prolapse Yes No Emphysema Yes No Blood Transfusion Artificial Heart Valve Yes No Chronic Cough Yes No Hemophilia	n Yes Yes Se Yes	N N N N N
Artificial Heart Valve	Yes se Yes	N N N N N
Heart Pacemaker Yes No Tuberculosis Yes No Sickle Cell Disease Rheumatic Fever Yes No Asthma Yes No Bruise Easily Arthritis/Rheumatism Yes No Hay Fever Yes No Liver Disease Cortisone Medicine Yes No Latex Sensitivity Yes No Yellow Jaundice Swollen Ankles Yes No Allergies or Hives Yes No Neurological Discont Stroke Yes No Sinus Trouble Yes No Epilepsy or Seizu Diet (Special/ Restricted) Yes No Radiation Therapy Yes No Fainting or Dizzy Artificial Joints (hip, knee, etc.) Yes No Tumors Yes No Psychiatric/Psycles 7. Do you use more than two pillows to sleep?	Se         Yes           Yes         Yes           Yes         Yes           Yes         Yes           Orders         Yes           Ires         Yes	N N N N
Rheumatic Fever	Yes Yes Yes Yes Orders Yes Yes Yes	N N N
Arthritis/Rheumatism Yes No Hay Fever Yes No Liver Disease Cortisone Medicine Yes No Latex Sensitivity Yes No Yellow Jaundice Swollen Ankles Yes No Allergies or Hives Yes No Neurological Disconstroke Yes No Sinus Trouble Yes No Epilepsy or Seizu Diet (Special/ Restricted) Yes No Radiation Therapy Yes No Fainting or Dizzy Artificial Joints (hip, knee, etc.) Yes No Chemotherapy Yes No Nervous/Anxious Kidney Trouble Yes No Tumors Yes No Psychiatric/Psycles No You was more than two pillows to sleep?	Yes Yes Orders Yes Yes Yes Yes	N N N
Cortisone Medicine Yes No Latex Sensitivity Yes No Yellow Jaundice Swollen Ankles Yes No Allergies or Hives Yes No Neurological Disconstroke Yes No Sinus Trouble Yes No Epilepsy or Seizu Diet (Special/ Restricted) Yes No Radiation Therapy Yes No Fainting or Dizzy Artificial Joints (hip, knee, etc.) Yes No Chemotherapy Yes No Nervous/Anxious Kidney Trouble Yes No Tumors Yes No Psychiatric/Psycles 7. Do you use more than two pillows to sleep?	Yes Yes Yes Yes	N N
Swollen Ankles	ordersYes	N
Stroke	iresYes	
Diet (Special/ Restricted)		N
Artificial Joints (hip, knee, etc.) Yes No Chemotherapy	Spells Yes	
7. Do you use more than two pillows to sleep?	•	
7. Do you use more than two pillows to sleep?		
	Totogroui Guro 100	
8. Have you lost or gained more than 10 pounds in the past year?	Yes	. N
	Yes	N
9. Do you have or have you had any disease, condition, or problem not listed?	Yes	. N
If yes, please list:	vol nillo? Von No	
10. Women. Are you: Pregnant? Yes,Months No Nursing? Yes No Taking birth contr	r <b>ol pills?</b> Yes No	
I understand the above in formation is necessary to provide me with dental care in a safe and efficient answered all questions to the best of my knowledge. Should further information be needed, you hask the respective health care provider or agency, who may release such information to you. I will any change in my health or medication.	nave my permission	n to
Patient /Guardian SignatureD	ate	
History Review		