MEDICAL HISTORY

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.

Family physicians name: _____

Are you under a physician's care now? ☐ Yes ☐ No Physicians name: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No _____

Have you had an orthopedic total joint replacement: ☐ 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 previously or currently taking Bone metabolism medications? ☐ Yes ☐ No (Examples: Actonel, Zometa, Boniva, Fosamax): _____

Please list all medications you are currently taking: _____

Are you allergic to any of the following? **(Please Circle)**

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other: Please List _____

Do you have or have had, any of the following? **(Please Circle)**

AIDS/HIV Positive	Chest Pain	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	Spinal 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/Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B/C	Radiation Treatments	Tuberculosis
Breathing problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors/Growth
Bruise Easily	Fainting Spells/ Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Cough	Hives/Rash	Rheumatic Fever*	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemia	Rheumatism	Yellow Jaundice

conditions may require medication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

Have you ever had any serious illness not listed above: ☐ Yes ☐ No ☐ N/A: _____

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 the 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

Continue Next Page→

Dental History

- When was the last time you saw a dentist? _____
- What was done at that time? _____
- What it the reason for your visit today? _____
- Have you ever been treated for periodontal disease? ☐ Yes ☐ No
- Have you had braces before? ☐ Yes ☐ No
- Does dental treatment make you nervous? ☐ Yes ☐ No
- Have you had an unpleasant dental experience? ☐ Yes ☐ No
- How often do you floss? _____
- What type of toothbrush do you use? (circle one) Soft Medium Hard Electric
- What other cleaning aids, devices or rinses do you use? _____

Do you experience any of the following?

- Bleeding or sore gums ☐ Yes ☐ No
- Bad breath/ unpleasant taste ☐ Yes ☐ No
- Tingling or burning tongue or lips ☐ Yes ☐ No
- Swelling or lumps in mouth ☐ Yes ☐ No
- Sores in mouth ☐ Yes ☐ No
- Food trapping between teeth ☐ Yes ☐ No
- Trouble swallowing without water ☐ Yes ☐ No
- Loose teeth ☐ Yes ☐ No
- Sensitive to hot ☐ Yes ☐ No
- Sensitive to cold ☐ Yes ☐ No
- Sensitive to sweets ☐ Yes ☐ No
- Clicking or popping jaw ☐ Yes ☐ No
- Frequent headaches ☐ Yes ☐ No
- Grinding or clenching ☐ Yes ☐ No

Smile Evaluation

	Yes	No
Are you self-conscious when you smile in front of other people or in pictures?	☐	☐
Do you ever cover your smile with your hand?	☐	☐
Do you have old filling or dental work that you don't like looking at?	☐	☐
Do you wish your teeth were whiter?	☐	☐
Do you dislike the shape of your teeth?	☐	☐
Do you have spaces between your teeth that you don't like?	☐	☐
Do you wish your teeth were straighter?	☐	☐
Are you unhappy with crowded or crooked teeth?	☐	☐

If you could wave a "magic wand" and change the appearance of you smile, how would you like it to look?

_____

Continue Next Page→