DENTAL HISTORY

PATIENT NAME ____

Welcome!
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? ____

____

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 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? 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 per day? ________________

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? 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 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

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 ____

MEDICAL HISTORY

PATIENT NAME ____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 receive. Thank you for answering the following questions.

1. Have you been under the care of a medical doctor for a major illness during the past two years? Yes No

   If yes, for what? ____

   Physician's Name ______________________ Phone ______________________

   Address ______________________ City ______________ State _____ ZIP ________

2. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medications? Yes No

   If yes, please list name and dosage or attach list: ______________________

   ____

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

   If yes, please indicate: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetic ☐ Other ________

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

   If yes, please explain: ____

Indicate which of the following you have had, or have at present with an ☒

☐ Heart (Surgery, Disease, Attack)	☐ Kidney Trouble	☐ A.I.D.S.
☐ Chest Pain	☐ Ulcers	☐ H.I.V. Positive
☐ Congenital Heart Disease	☐ Diabetes	☐ Cold Sores/Fever Blisters
☐ Heart Murmur	☐ Thyroid Problems	☐ Blood Transfusion
☐ High Blood Pressure	☐ Emphysema	☐ Hemophilia
☐ Mitral Valve Prolapse	☐ Chronic Cough	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Tuberculosis	☐ Bruise Easily
☐ Heart Pacemaker	☐ Asthma	☐ Liver Disease
☐ Rheumatic Fever	☐ Latex Sensitivity	☐ Neurological Disorders
☐ Arthritis Rhuematism	☐ Allergies or Hives	☐ Epilepsy or Seizures
☐ Cortisone Medicine	☐ Sinus Trouble	☐ Fainting or Dizzy Spells
☐ Swollen Ankles	☐ Radiation Therapy	☐ Nervous/Anxious
☐ Stroke	☐ Chemotherapy	☐ Psychiatric/Psychological Care
☐ Diet (Special Restricted)	☐ Tumors	☐ Drug Addiction
☐ Artificial Joints (hip, knee, etc.)	☐ Hepatitis A B C (Circle One)	

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

   If yes, please list: ____

6. **Women:** Are you ☐ Pregnant/May be pregnant – if indicated, how many months ________ ☐ Nursing ☐ Taking oral contraceptives

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Guardian Signature ______________________________ **Date** ______________

History Review

Clinician Initials ______ Date __________ Notes/Updates ______________________

Clinician Initials ______ Date __________ Notes/Updates ______________________

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