

# MEDICAL HISTORY

**Patient Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

Are you presently under a physician's care? \_\_\_\_ Physician's Name: \_\_\_\_\_ Reason: \_\_\_\_\_

Have you been hospitalized or had a major operation? \_\_\_\_ For what condition? \_\_\_\_\_

Are you taking any medications, pills or drugs? \_\_\_\_ Please List: \_\_\_\_\_

Are you allergic to any medications or substances? \_\_\_\_ Please Check: \_\_\_\_ Aspirin; \_\_\_\_ Penicillin; \_\_\_\_ Codeine; \_\_\_\_ Acrylic; \_\_\_\_ Metal; \_\_\_\_ Latex Rubber; \_\_\_\_ Other (please list) \_\_\_\_\_

WOMEN (please check): \_\_\_\_ Pregnant/Trying to get pregnant; \_\_\_\_ Nursing; \_\_\_\_ Taking Oral Contraceptives

Please Check Yes or No:

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease	__	__	Sickle Cell Disease	__	__	Ulcers	__	__	Cold Sores	__	__
Heart Murmur*	__	__	Hemophilia	__	__	Weight Loss	__	__	Herpes	__	__
Irregular Heartbeat	__	__	Leukemia	__	__	Diabetes	__	__	Stroke	__	__
Angina/Chest Pain	__	__	Swelling of Limbs	__	__	Hypoglycemia	__	__	Convulsions	__	__
Heart Attack	__	__	Lung Disease	__	__	Liver Disease	__	__	Epilepsy/Seizures	__	__
Mitral Valve Prolapse *	__	__	Breathing Problem	__	__	Hepatitis A	__	__	Fainting/Dizziness	__	__
Scarlet Fever	__	__	Frequent Cough	__	__	Hepatitis B or C	__	__	Glaucoma	__	__
Rheumatic Fever*	__	__	Hay Fever	__	__	Kidney Trouble	__	__	Tumors/Growths	__	__
Artificial Heart Valve*	__	__	Sinus Trouble	__	__	Renal Dialysis	__	__	Nervousness	__	__
Pace Maker	__	__	Asthma	__	__	Thyroid Disease	__	__	Psychiatric Care	__	__
Heart Surgery*	__	__	Emphysema	__	__	Arthritis/Gout	__	__	Alzheimer's Disease	__	__
High Blood Pressure	__	__	Tuberculosis	__	__	Rheumatoid	__	__	Anesthetic Reaction	__	__
Low Blood Pressure	__	__	Cancer	__	__	Arthritis	__	__	Allergies(Medicines)	__	__
Blood Disease	__	__	Radiation Tx	__	__	Jaw Pain	__	__	Allergies(Pollens)	__	__
Bruise Easily	__	__	Chemotherapy	__	__	Cortisone Tx	__	__	Hives/Rashes	__	__
Anemia	__	__	Stomach/Intestinal	__	__	Artificial Joint*	__	__			
Excessive Bleeding	__	__	Disease	__	__	HIV Positive	__	__			

\*if Yes to any of the starred conditions, please call prior to your appointment - Pre-medications may be required.

Do you have any other condition you would like us to know about? \_\_\_\_ Yes \_\_\_\_ No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

\_\_\_\_\_  
 PATIENT SIGNATURE (PARENT OR GUARDIAN) DATE

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_

## MEDICAL UPDATES

I have read my Medical History dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

DATE	ADDITIONS	SIGNATURE	BP	Reviewed by
_____	NONE	_____	_____	_____
_____	NONE	_____	_____	_____
_____	NONE	_____	_____	_____
_____	NONE	_____	_____	_____



# DENTAL HISTORY

Name: \_\_\_\_\_

**Yes No Please mark yes or no to the following questions:**

- Do your gums bleed when brushing, flossing, or eating?
- Do you have difficulty brushing or flossing an area?
- Does food collect between your teeth?
- Do you have a bad taste or odor in your mouth?
- Do you have any loose teeth, or have any teeth moved or shifted in the past two years?
- Do you or have you ever smoked? (packs/day\_\_\_\_) (when did you quit?\_\_\_\_)
- Have you ever been diagnosed or treated for periodontal disease?
- Do you have any family history of periodontal disease?
- Do you neglect flossing your teeth?
  
- Do you have toothaches, sore teeth, or dental pain?
- Are your teeth sensitive to hot, cold, sweets, biting, or touch?
- Do you have any broken teeth, missing fillings, or root canals?
- Do you have a dry mouth?
- Are you lacking fluoridated water or fluoride supplements?
- Have you had cavities diagnosed or treated within the last two years?
- Have you ever had a dental implant?
  
- Do you clench or grind your teeth? Are you awake or asleep when it occurs?
- Do you have soreness or pain in your jaw, ear, or side of your face?
- Do you get frequent headaches?
- Does your jaw ever pop, click, lock, or become fatigued or tired?
- Do you have difficulty opening, closing, or chewing certain types of foods?
- Do your teeth come together unevenly?
- Do you hit one tooth before the others when you bite?
- Do you wear a splint, biteguard, or had an injury to the head/neck, or had an auto accident?
  
- Are you dissatisfied with the appearance of your teeth?
- Do you dislike the color of your teeth or have noticeable spots or stains?
- Do you have existing crowns or dental work which you consider "ugly"?
- Do you have chips, spaces, crowded or crooked teeth that bother you?
- Are you self-conscious of your teeth or smile?
- Has anyone suggested you change your smile?
- Would you like to improve your smile?
  
- Have you ever had any complications from past dental treatment?
- Have you ever experienced any complications or reactions from local anesthetic?
- Have you ever had teeth extracted?
- Did you ever have braces or orthodontic treatment?
- Do you have any lumps, sores, or growths in your mouth?
- Does dental treatment cause you much worry or concern?
- Have you ever had an unpleasant dental experience in the past?
- Do you think your teeth are affecting your general health?

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