MEDICAL HISTORY

Patient Name	Medical Alert

1. Are you under a physician's care now? No Yes Physician's name & Phone _____
2. Have you ever been hospitalized or had a major operation? No Yes Describe: _____
3. Have you ever had a serious head or neck injury? No Yes Describe: _____
4. Are you currently taking any medication, drugs, pills or herbal remedies, including regular doses of aspirin? No Yes List: _____

_____

5. Have you ever taken any of the following weight loss drugs? Fen Phen Pondimen Redux Other _____
6. Have you ever taken any of the following bone loss prevention drugs? Fosamax Actonel Boniva Other.....
7. Are you on a special diet? No Yes Describe: _____
8. Do you use tobacco? No Yes Type, how long: _____
9. Do you use controlled substances? No Yes Describe: _____
10. Are you: Pregnant Trying to get pregnant Nursing Taking oral contraceptives
11. Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa drugs Local Anesthetics

Other: _____

12. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item:

AIDS/HIV Positive	Yes	No	Excessive Bleeding	Yes	No	Osteoporosis	Yes	No
Alzheimer's Disease	Yes	No	Excessive Thirst	Yes	No	Pain in Jaw Joints	Yes	No
Anaphylaxis	Yes	No	Fainting or Dizzy Spells	Yes	No	Parathyroid Disease	Yes	No
Anemia	Yes	No	Chronic Cough	Yes	No	Psychiatric/Psychological Care	Yes	No
Angina	Yes	No	Frequent Diarrhea	Yes	No	Radiation Therapy	Yes	No
Arthritis/Gout	Yes	No	Frequent Headaches	Yes	No	Recent Weight Loss	Yes	No
Artificial Heart Valve	Yes	No	Genital Herpes	Yes	No	Renal Dialysis	Yes	No
Artificial Joints (hip, knee, etc)	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Rheumatism	Yes	No
Blood Disease	Yes	No	Heart (Disease, Surgery Attack)	Yes	No	Scarlet Fever	Yes	No
Blood Transfusion	Yes	No	Heart Murmur	Yes	No	Shingles	Yes	No
Breathing Problems	Yes	No	Pacemaker	Yes	No	Sickle Cell Disease	Yes	No
Bruise Easily	Yes	No	Hemophilia	Yes	No	Sinus Trouble	Yes	No
Cancer	Yes	No	Hepatitis A B C (circle)	Yes	No	Spina Bifida	Yes	No
Chemotherapy	Yes	No	Herpes	Yes	No	Stomach/Intestinal Disease	Yes	No
Chest Pain	Yes	No	High/Low Blood Pressure	Yes	No	Stroke	Yes	No
Cold Sores/Fever Blisters	Yes	No	High Cholesterol	Yes	No	Swollen Limbs	Yes	No
Congenital Heart Disease	Yes	No	Hives/Rash	Yes	No	Thyroid Problems	Yes	No
Convulsions	Yes	No	Hypoglycemia	Yes	No	Tonsillitis	Yes	No
Cortisone Medicine	Yes	No	Irregular heartbeat	Yes	No	Tuberculosis	Yes	No
Diabetes (I, II)	Yes	No	Kidney Trouble	Yes	No	Tumors	Yes	No
Drug Addiction	Yes	No	Leukemia	Yes	No	Ulcers	Yes	No
Easily Winded	Yes	No	Liver Disease/Yellow Jaundice	Yes	No	Venereal Disease	Yes	No
Emphysema	Yes	No	Lung Disease	Yes	No	Nervous/Anxious	Yes	No
Epilepsy or Seizures	Yes	No	Mitral Valve Prolapse	Yes	No	Other _____		

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.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

DENTAL HISTORY

Patient Name	**Medical Alert**

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_____Telephone_____

Address_____ State_____ Zip_____

How often do you have dental exams?_____ How often do you brush your teeth?_____

How often do you floss? _____ What other dental aids do you use? _____

Do you have any dental problems now? Yes No If yes, please describe:_____

Are any of your teeth sensitive to:

Hot/Cold	Yes	No
Sweets	Yes	No
Biting/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 a 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

Packs/day_____ Years_____

Have you ever had:

Orthodontic Treatment	Yes	No
Oral Surgery	Yes	No
Periodontal Treatment	Yes	No
Your teeth ground or bite adjusted	Yes	No
A bite plate or mouth guard	Yes	No
A serious injury to the mouth or head?	Yes	No

Describe:_____

Have you experienced:

Jaw clicking or popping	Yes	No
Pain (joint, ear, side of face)	Yes	No
Difficulty opening or closing the mouth	Yes	No
Difficulty in chewing on either side of the mouth	Yes	No
Headaches, neckaches or shoulde aches	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 so, please describe _____

Have you been told to take premedication prior to dental treatment? Yes No If so, for what?_____

Is there anything else about having dental treatment that you would like us to know? Yes No

Please describe:_____

_____