MEDICAL HISTORY

Patient Name_____
Medical Alert_____

Have you been under the care of a medical doctor during the past two years? Yes No
Physician's Name _____
Address_____
Phone_____

Are you taking any medication, drugs, or pills now, including regular doses of aspirin? Yes No
If yes, please list drugs and dosage:_____

Are you allergic to any medication or substance? Yes No
If yes, please list:_____

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other similar drugs? Yes No

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

Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum) or C (please circle)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	STD	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Liver Disease	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Yellow Jaundice	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No			

Do you use more than two pillows to sleep? Yes No

Have you lost or gained more than 10 pounds in the past year? Yes No

Do you have or have you had any disease, condition, or problem not listed? Yes No
If yes, please list:_____

Women:
Are you: **Pregnant**? Yes, _____ months No **Nursing**? Yes No **Taking birth control pills**? Yes No

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 change in my health or medication.

Patient/Guardian Signature _____ Date _____

(Please complete other side)

DENTAL HISTORY

Patient Name_____
Medical Alert_____

Welcome! *So that we may provide you with the best possible care please complete both sides of this dental/medical history form. 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?_____
Previous Dentist's Name_____

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 you dissatisfied with the appearance of your teeth? Yes No **What would you change if you could?** _____
_____

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.** _____

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 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 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?		
Have your parents experienced gum disease or tooth loss?	Yes	No

Have you ever experienced:

Clenching or grinding your teeth while awake or asleep?	Yes	No
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)		
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches, or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Tired jaws, especially in the morning?	Yes	No
Mouth breathing while awake or asleep?	Yes	No

Have you been told that you snore?	Yes	No
Are you often tired during the day?	Yes	No
Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	Yes	No

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
0 = no chance of dozing, 1 = slight chance of dozing,
2 = moderate chance of dozing, 3 = high chance of dozing

Sitting and reading	
Watching TV	
Sitting inactive in a public place (theater, meeting, etc.)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Have you ever used a CPAP?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If yes, please describe, including cause:		

Do you smoke/chew tobacco?	Yes	No
If yes, how much?		

(Please complete other side)