Dental History Form

Patient Name: Jules Lopez **Patient Account No.** 123-456-000

Medical Alert: Tooth ache

Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.
All information is completely confidential.

What is the reason for your visit today? Toothache

Date of last dental visit? January 23, 2023 Last dental cleaning: January 23, 2023 Last full mouth X-Rays: 5 years ago

What was done at your last dental visit? Cleaning

Previous Dentist's Name: Dr. Anne Curtis Telephone:

Address: 123 Elm St. Greenland State: Arizona Zip: 1234

How often do you have dental examinations? Not too often

How often do you brush your teeth? 3 times a day How often do you floss? once a day

Have you ever used or are you currently using topical fluoride? ☐ Yes ☑ No

What other dental aids do you use (Interplak, toothpick, etc.)? toothpick

Do you have any dental problems now? ☑ Yes ☐ No

If yes, please describe: I have been having toothaches for two days now, and my gum is swelling.

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 (pencils, pipe, pins, nails, fingernails)?	☑ 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

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

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, neck aches 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? Pain and injection

Have you ever had an upsetting dental experience? ☐ Yes ☑ No

If yes, please describe

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☑ No

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

If yes, please describe

Medical History Form

Patient Name: Jules Lopez **Patient Account No.** 123-456-000

Medical Alert: Toothache

1. Physician's Name: Dr. Liz Uy Phone (+2) 777- 1234

   Have you had any medical care within the past two years? ☐ Yes ☑ No

   Describe:

2. Have you taken any medication or drugs during the past two years? ☑ Yes ☐ No
3. Are you currently taking an medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ☑ Yes ☐ No
4. Have you ever taken prescription medications for weight loss (diet pills)? ☐ Yes ☑ No

   If yes, did you take any of the following? ☐ Fen-Phen ☐ Pondimen ☐ Redux ☐ Other

   If you said yes to any of the above, did you have a medical exam for heart issues? ☐ Yes ☑ No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ☐ Yes ☑ No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ☐ Yes ☑ No

   If yes, please specify
7. Have you been a patient in the hospital during the past five years? ☑ Yes ☐ No
8. Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack) ☐ Yes ☑ No	Ulcers ☐ Yes ☑ No	Venereal Disease ☐ Yes ☑ No	
Chest Pain ☐ Yes ☑ No	Diabetes ☐ Yes ☑ No	AIDS/HIV Positive ☐ Yes ☑ No	
Congenital Heart Disease ☐ Yes ☑ No	Thyroid Problems ☐ Yes ☑ No	Cold Sores/Fever Blisters ☐ Yes ☑ No	
Heart Murmur ☐ Yes ☑ No	Glaucoma ☐ Yes ☑ No	Blood Transfusion ☐ Yes ☑ No	
High/Low Blood Pressure ☐ Yes ☑ No	Contact Lenses ☐ Yes ☑ No	Hemophilia ☐ Yes ☑ No	
Artificial Heart Valve/ Pacemaker ☐ Yes ☑ No	Emphysema ☐ Yes ☑ No	Sickle Cell Disease ☐ Yes ☑ No	
Rheumatic Fever ☐ Yes ☑ No	Chronic Cough ☐ Yes ☑ No	Bruise Easily ☐ Yes ☑ No	
Arthritis/Rheumatism ☐ Yes ☑ No	Tuberculosis ☐ Yes ☑ No	Liver Disease/Yellow Jaundice ☐ Yes ☑ No	
Cortisone Medicine ☐ Yes ☑ No	Asthma ☐ Yes ☑ No	Neurological Disorders ☐ Yes ☑ No	
Swollen Ankles ☐ Yes ☑ No	Hay Fever/Allergy/ Hives ☐ Yes ☑ No	Epilepsy or Seizures ☐ Yes ☑ No	
Stroke ☐ Yes ☑ No	Latex Sensitivity ☐ Yes ☑ No	Fainting or Dizzy Spells ☐ Yes ☑ No	
Diet (Special/Restricted) ☐ Yes ☑ No	Sinus Trouble ☐ Yes ☑ No	Nervous/Anxious ☐ Yes ☑ No	
Artificial Joints (Hip, Knee, etc.) ☐ Yes ☑ No	Radiation Therapy ☐ Yes ☑ No	Psychiatric/ Psychological Care ☐ Yes ☑ No	
Kidney Trouble ☐ Yes ☑ No	Chemotherapy ☐ Yes ☑ No		
	Tumors ☐ Yes ☑ No		
	Hepatitus A, B, C ☐ A ☐ B ☐ C		

9. Have you lost or gained more than 10 pounds in the last year? ☐ Yes ☑ No
10. Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☑ No
11. Women: Are you pregnant or think you could be pregnant? ☐ Yes Months ☑ No Nursing? ☐ Yes ☐ No
12. Do you use birth control prescriptions? ☐ Yes ☑ No

I understand the above information in 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: Jules Lopez Date: September 1, 2023

History Review

Dentist Signature: Dr. Liz Uy Date: September 1, 2023