Dental History Form

Patient's full name:	**Patient's ID#:**
Attending dentist's full name:	**Date submitted:**

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

What is the reason for your visit today?

Date of last dental visit:	**Last dental cleaning date:**	**Last full-mouth X-ray date:**

What was done during your last dental visit?

Previous dentist's name:	**Contact number:**

Address (including state and zipcode):

How often do you have dental examinations?

How often do you brush your teeth?	**How often do you floss?**

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

What dental aids do you use (e.g., Interplak, toothpicks, etc.)?

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

Are any of your teeth sensitive to…

Hot and 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? *If yes, where?*	◯ Yes ◯ No

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? *If yes, where?*	◯ Yes ◯ No

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? *If so, what is your biggest concern?*	◯ Yes ◯ No
Have you ever had an upsetting dental experience? *If yes, please describe:*	◯ Yes ◯ No

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

1. **Have you had any medical care within the past two years?** ◯ Yes ◯ No
   If yes, please 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 ticked 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 describe:

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" for 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		
		Hepatitis (A, B, or C)	◯ Yes ◯ No		

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. **For women only: Are you pregnant or think you could be pregnant?** ◯ Yes ◯ No
    If yes, how many months have you been pregnant (whether you think it or if you actually are)? _____ months
    Are you 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's signature:	**Date signed:**
Parent/guardian's signature (if the patient is a minor):	**Date signed:**
Attending dentist's signature:	**Date signed:**