Medical and Dental History

PRINT PATIENT'S NAME: _____ **BIRTHDATE:** _____

DENTAL HISTORY

PURPOSE of INITIAL VISIT:
HOW LONG SINCE you have seen a dentist?
Date of Last COMPLETE Dental Exam:
Date of Last FULL MOUTH X-RAYS (16 small films or panoramic):

Do you REGULARLY BRUSH and use DENTAL FLOSS?	YES	NO
Do your GUMS ever BLEED?	YES	NO
Have you had any PERIODONTAL (GUM) TREATMENTS?	YES	NO
Does food get CAUGHT between your teeth?	YES	NO
Are you teeth ever SENSITIVE? Circle: HOT COLD SWEETS PRESSURE		
Do you ever have CLICKING, POPPING, OR DISCOMFORT IN THE JAW JOINT?	YES	NO
Do you CLENCH OR GRIND your teeth?	YES	NO
Have you LOST any teeth or have any teeth been REMOVED?	YES	NO
How were these teeth REPLACED? Circle: FIXED BRIDGE REMOVABLE BRIDGE DENTURE NOT REPLACED		
Are you UNHAPPY with the replacement?	YES	NO
Would you like to know about PERMANENT REPLACEMENT?	YES	NO
Do you have any SORES or GROWTHS in your mouth?	YES	NO
Do you feel your BREATH is offensive at times?	YES	NO
Are you APPREHENSIVE about dental treatment?	YES	NO
Have you ever had ORTHODONTIC work?	YES	NO
Are any of your teeth LOOSE, TIPPED, SHIFTED, OR CHIPPED?	YES	NO
Do you have DISCOLORED teeth that bother you?	YES	NO
Would you like your smile to LOOK BETTER or DIFFERENT?	YES	NO

MEDICAL HISTORY

Are you under a PHYSICIAN'S CARE now? For What?
NAME of physician providing care: Telephone:
Have you been HOSPITALIZED recently or have you had any MAJOR OPERATIONS? Please explain:
Have you ever had a serious INJURY to your HEAD or NECK? Explain:
What MEDICATIONS, PILLS, OR DRUGS are you taking?
What MEDICATIONS OR SUBSTANCES are you ALLERGIC to? (i.e., aspirin, penicillin, codeine, acrylic, metal, latex rubber, other, etc.)

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease/Attack
Heart Murmur
Angina/Chest Pain
Congenital Heart Disorder
Mitral Valve Prolapse
Artificial Heart Valve
Heart Surgery
Heart Pacemaker
Rheumatic Fever
Anemia
Stroke
High/Low Blood Pressure
Blood Transfusion
Excessive Bleeding/Hemophilia
Bruises Easily
Sickle Cell Disease
Hypoglycemia
Diabetes
Liver Trouble

Kidney Trouble
Renal Dialysis
Thyroid Disease
Arthritis/Rheumatism
Pain in Jaw Joint/TMJ Disorder
Tuberculosis
Asthma
Emphysema
Epilepsy/Seizures
Dizziness/Fainting
Cancer
Chemotherapy
Radiation Therapy
Glaucoma
Stomach Problems/Ulcers
Artificial Joint/Prosthesis
AIDS
HIV Positive
Herpes

Venereal Disease
Hepatitis A, B, or C (Circle Type)
Fever Blisters/Cold Sores
Nervousness/Panic Attacks
Psychiatric Care
Alzheimer's Disease
Pregnant/Trying to Get Pregnant
Cortisone Medications
Smoker
Drug Addiction
Sinus Trouble
Codeine Allergy
Penicillin Allergy
List Other Allergies:
_____
_____
_____

Have you ever had another serious illness not listed above? Explain: _____

I acknowledge that all the preceding answers are correct, by my signature below**. If I have any changes in my health status, or if my medicines change, I will inform the dentist and staff at my next appointment, without fail**.

_____ _____

Patient's or Guardian's Signature Date