

MEDICAL & DENTAL HISTORY

Patient's Full Name: _____ Sex _____ Date Of Birth: ___/___/___
Patient's Current or Previous Dentist: _____ Date Of Last Cleaning: ___/___/___
Patient's Current or Previous Physician: _____ Date Of Last Exam: ___/___/___

All past medical and dental history may be important for your optimal care. Please take time to be as accurate and thorough as possible in answering the following questions. Use space at bottom if necessary. Thank You

- A. Please list chief concerns for treatments: (# in order of priority): _____

- B. Describe anything that bothers you about the appearance of your teeth, smile, or face: _____

- C. Describe any injuries or blows to your face, jaw, mouth or teeth: _____

- D. List all current medications including non-prescriptions: _____

- E. List all drug allergies: _____

- F. List all previous surgeries or hospitalizations: _____

Please circle yes or no to every question. And thoroughly describe. (Use space at bottom if necessary.)

Medical

- 1. High blood pressure Y / N _____
- 2. Chest pains or heart attack Y / N _____
- 3. Stroke Y / N _____
- 4. Rheumatic fever Y / N _____
- 5. Shortness of breath or swollen ankles Y / N _____
- 6. Heart trouble, murmur, or mitral valve prolapse Y / N _____
- 7. Artificial joint replacements (heart, valve, hip) Y / N _____
- 8. Any lung disease Y / N _____
- 9. Asthma Y / N _____
- 10. Allergies or hay fever Y / N _____
- 11. Sinus problems Y / N _____
- 12. Mouth breathing or excessive snoring Y / N _____
- 13. Ulcers or stomach problems Y / N _____
- 14. Diabetes Y / N _____
- 15. Hepatitis or liver disease Y / N _____
- 16. Kidney or bladder disease Y / N _____
- 17. Thyroid trouble _____
- 18. Connective tissue disease Y / N _____
- 19. Sexually transmitted disease Y / N _____
- 20. Arthritis or rheumatism Y / N _____
- 21. Cancer (type, date) Y / N _____
- 22. Serious illnesses not listed (list type, date) _____
- 23. Subject to prolonged bleeding or bruise easily Y / N _____
- 24. A contact lens user Y / N _____
- 25. Glaucoma Y / N _____
- 26. Epilepsy, convulsions or seizures Y / N _____
- 27. Psychiatric therapy or emotional problems Y / N _____
- 28. Do you have HIV (AIDS) Y / N _____
- 29. Pregnant or possible pregnant Y / N _____

- 30. Taking birth control pills Y / N _____
- 31. Drink coffee Y / N _____
- 32. Use tobacco (types, quantity) Y / N _____
- 33. Consume alcoholic beverages Y / N _____
- 34. Pain, popping, locking jaws Y / N _____
- 35. Clench or grind teeth Y / N _____
- 36. Wake up with sore jaws Y / N _____
- 37. Frequent headaches Y / N _____
- 38. Dizziness, ringing or pain in ears Y / N _____
- 39. Tenderness in jaw, neck, back Y / N _____

Dental

- 40. History of TMJ Y / N _____
- 41. Gum disease Y / N _____
- 42. Orthodontic therapy Y / N _____
- 43. Had any oral surgery Y / N _____
- 44. Dental x-rays taken in last year Y / N _____
- 45. Excessive fear of dental treatment Y / N _____
- 46. Brush your teeth (how often) Y / N _____
- 47. Floss your teeth (how often) Y / N _____
- 48. Bad breath or taste in mouth Y / N _____
- 49. Bleeding gums Y / N _____
- 50. Sore teeth Y / N _____
- 51. Tooth sensitivity (hot, cold) Y / N _____
- 52. Fever blisters or mouth ulcers Y / N _____
- 53. Suck your thumb, finger, lip Y / N _____
- 54. Tongue thrusting habit Y / N _____
- 55. Gag easily Y / N _____
- 56. Place a high priority on keeping teeth Y / N _____

The above information is accurate and complete to the best of my knowledge.

Date ___/___/___ Patient or Guardian's Signature _____ Dr. Signature _____