**MEDICAL HISTORY**

**Medical Alert**

**Patient Account No.**

**Patient Name**

1. Physician’s Name Phone ( ) Have you had any medical care within the past two years? ....................................................................................................................

Describe 2. Have you taken any medication or drugs during the past two years? .....................................................................................................

If yes, please list name and dosage

1. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ...................................

If yes, please list name and dosage

1. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ................................

If yes, please list name and dosage

1. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? .................................................................

If yes, please specify

6. Have you been a patient in the hospital during the past five years? .......................................................................................................

7. Indicate which of the following you have had, or have at present. Circle “yes” or “no” to each item.

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Heart (Surgery, Disease, Attack) ...  Chest Pain................................... | Yes  Yes | No  No | Ulcers.........................  Diabetes....................... | Yes  Yes | No  No | Hepatitis A B C (circle) ...  Venereal Disease....................... | Yes  Yes | No  No |
| Congenital Heart Disease........... | Yes | No | Thyroid Problems........................ | Yes | No | A.I.D.S./H.I.V. Positive ................ | Yes | No |
| Heart Murmur.............................. | Yes | No | Glaucoma.................................... | Yes | No | Cold Sores/Fever Blisters.......... | Yes | No |
| High/Low Blood Pressure............ | Yes | No | Contact lenses............................ | Yes | No | Blood Transfusion...................... | Yes | No |
| Mitral Valve Prolapse................... | Yes | No | Emphysema................................. | Yes | No | Hemophilia................................ | Yes | No |
| Artificial Heart Valve/Pacemaker......... | Yes | No | Chronic Cough............................ | Yes | No | Sickle Cell Disease.................... | Yes | No |
| Rheumatic Fever.......................... | Yes | No | Tuberculosis................................ | Yes | No | Bruise Easily.............................. | Yes | No |
| Arthritis/Rheumatism................... | Yes | No | Asthma........................................ | Yes | No | Liver Disease/Yellow Jaundice... | Yes | No |
| Cortisone Medicine..................... | Yes | No | Hay Fever/Allergy/Hives.............. | Yes | No | Neurological Disorders.............. | Yes | No |
| Swollen Ankles............................ | Yes | No | Latex Sensitivity.......................... | 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 | Cancer........................................ | Yes | No |

8. Have you lost or gained more than 10 pounds in the past year? .............................................................................................................

9. Do you have or have you had any disease, condition, or problem not listed? .........................................................................................

If yes, please list:

10. **Women:** Are you pregnant or think you could be pregnant? Yes Months No **Nursing?** Yes No 11. Do you use birth control prescriptions? ...................................................................................................................................

Yes No

Yes No

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 any change in my health or medication.

Patient/Guardian Signature Date

**History Review**

Dentist Signature Date

**DENTAL HISTORY**

**Medical Alert**

**Patient Account No.**

**Patient Name**

***Welcome!*** *So that we may provide you with the best possible care please complete both sides of this medical/dental 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 Telephone Address State Zip

**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 currently using topical fluoride? Yes No

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Are any of your teeth sensitive to:** |  | **Have you ever had:** |  |
| Hot or cold? Yes | No | Orthodontic treatment? Yes | No |
| Sweets? Yes | No | Oral Surgery? Yes | No |
| Biting or Chewing? Yes | No | Periodontal treatment? Yes | No |
| Have you noticed any mouth odors or bad tastes? Yes | No | Your teeth ground or the bite adjusted? Yes | No |
| Do you frequently get cold sores, blisters or any other oral lesions? Yes | No | A bite plate or mouth guard? Yes | No |
|  |  | A serious injury to the mouth or head? Yes | No |
| Do your gums bleed or hurt? Yes | No | Please describe, including cause |  |
| Have your parents experienced gum disease or tooth loss? Yes  Have you noticed any loose teeth or change in your bite? Yes | No  No | **Have you experienced:** |  |
| Does food tend to become caught in between your teeth? Yes | No | Clicking or popping of the jaw? Yes | No |
| If yes, where |  | Pain? (joint, ear, side of face) Yes | No |
| **Do you:** |  | Difficulty in opening or closing the mouth? Yes  Difficulty in chewing on either side of the mouth? Yes | No  No |
| Clench or grind your teeth while awake or asleep? Yes | No | Headaches, neckaches or shoulder aches? Yes | No |
| Bite your lips or cheeks regularly? Yes | No | Sore muscles (neck, shoulders)? Yes | No |
| Hold foreign objects with your teeth? (Pencils, pipe, etc.) Yes  Mouth breathe while awake or asleep? Yes | No  No | ..........................................................................................  **Are you satisfied with your teeth’s appearance?** Yes | No |
| Have tired jaws, especially in the morning? Yes | No | Would you like to replace your silver fillings? Yes | No |
| Snore or have any other sleeping disorders? Yes | No | Would you like to keep all of your teeth all of your life? Yes | No |
| Smoke/chew tobacco or use other tobacco products? Yes | No |  |  |

## Do you feel nervous about having dental treatment? ....................................................................................................................................................................... Yes No

Please describe

Have you ever had an upsetting dental experience? ....................................................................................................................................................................... Yes No

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