

Patient Name: \_\_\_\_\_  
 Last First MI

Birth Date: \_\_\_\_\_

**MEDICAL AND DENTAL HISTORY**

Please print and answer all questions and sign the last page. All information provided is confidential.

**GENERAL HEALTH**

Physician: \_\_\_\_\_  
 Name

**BP:** \_\_\_\_\_ **P:** \_\_\_\_\_  
 Address

Phone #

Have you ever had any of the following:

- |                       |                       |                                 |                       |                       |                         |                       |                       |                             |
|-----------------------|-----------------------|---------------------------------|-----------------------|-----------------------|-------------------------|-----------------------|-----------------------|-----------------------------|
| <b>Yes</b>            | <b>No</b>             |                                 | <b>Yes</b>            | <b>No</b>             |                         | <b>Yes</b>            | <b>No</b>             |                             |
| <input type="radio"/> | <input type="radio"/> | Heart problem/murmur/attack     | <input type="radio"/> | <input type="radio"/> | High blood pressure     | <input type="radio"/> | <input type="radio"/> | Latex allergy               |
| <input type="radio"/> | <input type="radio"/> | Shortness of breath             | <input type="radio"/> | <input type="radio"/> | Low blood pressure      | <input type="radio"/> | <input type="radio"/> | Artificial joints           |
| <input type="radio"/> | <input type="radio"/> | Bleeding problem                | <input type="radio"/> | <input type="radio"/> | Kidney problems         | <input type="radio"/> | <input type="radio"/> | Chemical dependency         |
| <input type="radio"/> | <input type="radio"/> | Liver problem                   | <input type="radio"/> | <input type="radio"/> | Rheumatic fever         | <input type="radio"/> | <input type="radio"/> | Circulatory problems        |
| <input type="radio"/> | <input type="radio"/> | Artificial heart valves         | <input type="radio"/> | <input type="radio"/> | Tuberculosis            | <input type="radio"/> | <input type="radio"/> | Fainting                    |
| <input type="radio"/> | <input type="radio"/> | Hepatitis A B C                 | <input type="radio"/> | <input type="radio"/> | AIDS/HIV                | <input type="radio"/> | <input type="radio"/> | Cholesterol problems        |
| <input type="radio"/> | <input type="radio"/> | Anemia                          | <input type="radio"/> | <input type="radio"/> | Swollen ankles          | <input type="radio"/> | <input type="radio"/> | Pacemaker                   |
| <input type="radio"/> | <input type="radio"/> | Excessive thirst                | <input type="radio"/> | <input type="radio"/> | Stomach ulcers          | <input type="radio"/> | <input type="radio"/> | Thyroid problems            |
| <input type="radio"/> | <input type="radio"/> | Frequent urination              | <input type="radio"/> | <input type="radio"/> | Delayed wound healing   | <input type="radio"/> | <input type="radio"/> | Psychiatric care            |
| <input type="radio"/> | <input type="radio"/> | Diabetes Type I or II           | <input type="radio"/> | <input type="radio"/> | Hemophilia              | <input type="radio"/> | <input type="radio"/> | Back problems               |
| <input type="radio"/> | <input type="radio"/> | Organ Transplant                | <input type="radio"/> | <input type="radio"/> | Arthritis or rheumatism | <input type="radio"/> | <input type="radio"/> | Chemotherapy                |
| <input type="radio"/> | <input type="radio"/> | Venereal disease                | <input type="radio"/> | <input type="radio"/> | Epilepsy, seizures      | <input type="radio"/> | <input type="radio"/> | Cortisone/steroid treatment |
| <input type="radio"/> | <input type="radio"/> | Cancer or radiation therapy     | <input type="radio"/> | <input type="radio"/> | Osteoporosis            | <input type="radio"/> | <input type="radio"/> | Headaches                   |
| <input type="radio"/> | <input type="radio"/> | Anticoagulants (blood thinners) | <input type="radio"/> | <input type="radio"/> | Glaucoma                | <input type="radio"/> | <input type="radio"/> | Nervous problems            |
| <input type="radio"/> | <input type="radio"/> | Asthma                          | <input type="radio"/> | <input type="radio"/> | Hay Fever               | <input type="radio"/> | <input type="radio"/> | Skin rash                   |
| <input type="radio"/> | <input type="radio"/> | Prostate problems (males)       | <input type="radio"/> | <input type="radio"/> | Respiratory disease     | <input type="radio"/> | <input type="radio"/> | Mitral valve prolapse       |
| <input type="radio"/> | <input type="radio"/> | Stroke                          | <input type="radio"/> | <input type="radio"/> | Emphysema               | <input type="radio"/> | <input type="radio"/> | Herpes                      |
| <input type="radio"/> | <input type="radio"/> | Scarlet fever                   | <input type="radio"/> | <input type="radio"/> | Sinus problems          | <input type="radio"/> | <input type="radio"/> | Smoking                     |

Other: \_\_\_\_\_

Please answer the following:

- |                       |                       |  |
|-----------------------|-----------------------|--|
| <b>Yes</b>            | <b>No</b>             |  |
| <input type="radio"/> | <input type="radio"/> | 1. Are you presently under the care of a physician? Reason _____         |
| <input type="radio"/> | <input type="radio"/> | 2. Have you been hospitalized in the last 10 years? Reason _____         |
| <input type="radio"/> | <input type="radio"/> | 3. Have you had any serious illnesses or operations? Describe _____      |
| <input type="radio"/> | <input type="radio"/> | 4. Do you faint easily? _____  |
| <input type="radio"/> | <input type="radio"/> | 5. Have you taken cortisone or steroids in the last 6 mos.? Reason _____ |
| <input type="radio"/> | <input type="radio"/> | 6. Are you or do you suspect that you may be pregnant? (Females) _____   |
| <input type="radio"/> | <input type="radio"/> | 7. Are you taking any birth control medication? If so, list _____        |
| <input type="radio"/> | <input type="radio"/> | 8. Are you taking hormone replacement therapy? If so, list _____         |
| <input type="radio"/> | <input type="radio"/> | 9. Have you ever had any reaction to anesthesia? If so, list _____       |
| <input type="radio"/> | <input type="radio"/> | 10. Have you ever taken Fen-Phen or Redux? If so, when? _____            |
| <input type="radio"/> | <input type="radio"/> | 11. Do you have a family history of any diseases? Describe _____         |

Please list **ALL** medications that you are currently taking or have taken in the last 6 months. Please include vitamins.

Medication	Dosage	Reason	When started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Allergies:**

- Aspirin       Erythromycin       Codeine       Local anesthetic       Latex       Sulfa       Penicillin
- Other \_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

**DENTAL HISTORY**

Reason for today's visit: \_\_\_\_\_

Date of last FULL MOUTH X-rays: \_\_\_\_\_

Check if you have had any of the following:

- Bad breath       Bleeding gums       Clicking or popping of jaw       Grinding teeth
- Loose teeth       Sensitivity to hot or cold       Dental Implants       Sensitivity to sweets
- Mouth sores       Pain when chewing       Receding gums       Clenching teeth
- Bite change       TMJ problems       Orthodontics (braces)       Headaches

Please answer the following questions:

1. How would you describe your dental health?    EXCELLENT    GOOD    FAIR    POOR
2. What kind of toothbrush do you use?    SOFT    MEDIUM    HARD    ELECTRIC    Type? \_\_\_\_\_
3. How often do you brush? \_\_\_\_\_
4. How often do you floss? \_\_\_\_\_
5. Do you use any of the following?    STIMUDENTS    RUBBER TIP    SUPERFLOSS    PROXABRUSH  
OTHER \_\_\_\_\_
6. What kind of toothpaste do you use? \_\_\_\_\_ Oral rinse? \_\_\_\_\_
7. Estimate the number of cups, glasses, etc. you consume each day of:  
Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Soft drinks \_\_\_\_\_ Alcoholic beverages \_\_\_\_\_
8. When was your last dental cleaning? \_\_\_\_\_

**Yes No**

- 9. Are you having trouble chewing satisfactorily?
- 10. Have you noticed spaces developing between your teeth?
- 11. Do you awaken with sore jaws?
- 12. Do you notice popping, clicking, grating or soreness in the joints just in front of your ears?
- 13. Have you ever been treated for TMJ (temporomandibular joint) problems?  
Describe \_\_\_\_\_
- 14. Have you ever had a frightening experience in a dental office ? Describe \_\_\_\_\_
- 15. Have you had previous gum trouble or treatment? Describe: \_\_\_\_\_
- 16. Have you had a previous gum abscess or gum boil? Describe: \_\_\_\_\_
- 17. Would wearing a partial denture or false teeth bother you?

18. What concerns you most about your mouth? \_\_\_\_\_

19. Have you **ever** smoked? YES NO How many packs per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

20. If you are a past smoker, when did you quit? \_\_\_\_\_

Signature of Patient or Legal Guardian \_\_\_\_\_

Date: \_\_\_\_\_

Doctor Signature \_\_\_\_\_

Date: \_\_\_\_\_

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