



Patient Name: _____ Date of Birth: _____

Physician's Name: _____ Physician's Phone #: _____

Purpose of last physician visit: _____

MEDICAL HISTORY

Last physician visit: _____ General health? Poor Fair Good

HAVE YOU EVER HAD THE FOLLOWING:?

Circle:	Allergic reaction to:	Diagnosis Date
YES NO	Penicillin or other antibiotics	_____
YES NO	Aspirin or Ibuprofen	_____
YES NO	Tetracycline	_____
YES NO	Codeine or sedatives	_____
YES NO	Latex	_____
YES NO	Nut allergy	_____
YES NO	Other medications _____	_____

Circle:	Condition:	Diagnosis Date
YES NO	Liver Disease	_____
YES NO	Hepatitis or jaundice	_____
YES NO	Kidney disease	_____
YES NO	Thyroid or parathyroid problems	_____
YES NO	Ulcers	_____
YES NO	Digestive disorders / acid reflux	_____
YES NO	Diabetes (Insulin / Diet Controlled)	_____
YES NO	Arthritis	_____
YES NO	Glaucoma	_____
YES NO	Artificial joints (hip, knee, etc.)	_____
YES NO	Head or neck injuries	_____
YES NO	Epilepsy, convulsions (seizures)	_____
YES NO	Currently pregnant	_____
YES NO	Cold sores / fever blisters	_____
YES NO	AIDS or HIV infection	_____
YES NO	Sexually transmitted disease	_____
YES NO	Steroid medication	_____
YES NO	Cancer	_____
YES NO	Chemotherapy	_____
YES NO	Radiation therapy	_____
YES NO	Emotional problems	_____
YES NO	Psychiatric treatment	_____
YES NO	Antidepressant medication	_____
YES NO	Alcohol / drug dependency	_____
YES NO	Hearing problems	_____
YES NO	Osteoporosis or bone disorders	_____
YES NO	High Cholesterol	_____
YES NO	Sleep Apnea	_____
YES NO	Are you a smoker ? _____ Packs per day	_____
YES NO	Do you use smokeless tobacco?	_____

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment: _____

Please list ALL medications, herbal supplements and/or vitamins taken within the last two years, including osteoporosis medications, including Fosamax or Alendronate: _____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

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 of agency, who may release such information to you.

SIGNATURE: _____ **DATE:** _____

DOCTOR'S REMARKS: _____



Patient Name: _____ Last Dental Exam: _____

Last Dental Treatment _____ Last Dental X-Rays _____

Previous Dentist: _____ How long with this dentist: _____

How often are your teeth cleaned? _____

What is your immediate dental concern? _____

PLEASE ANSWER BY CIRCLING YES OR NO TO THE FOLLOWING:

- YES NO Is there anything you would like to change about the look or feel of your teeth?
- YES NO Dental fears or unfavorable experiences?
- YES NO Problems with effectiveness or bad reactions to dental anesthetics?
- YES NO Orthodontic treatment? (Date _____)
- YES NO Periodontal (gum) treatment?
- YES NO Avoid brushing any part of your mouth?
- YES NO Have gums that bleed when brushing or flossing?
- YES NO Have teeth that are sensitive to hot or cold?
- YES NO Have sore or painful teeth?
- YES NO Have a burning sensation in your mouth?
- YES NO Have difficulty swallowing?
- YES NO Have an unpleasant taste or odor in your mouth?
- YES NO Dry mouth, throat, and/or eyes?
- YES NO Jaw problems (temporomandibular joint)?
- YES NO Difficulty in opening your mouth widely?
- YES NO Stiff neck muscles?
- YES NO Awaken with an awareness of your teeth or jaws?
- YES NO Have tension headaches?
- YES NO Clench or grind your teeth?
- YES NO Lost any teeth?
- YES NO Wear a bite splint, night guard, orthodontic retainer or sleep apnea appliance?
- YES NO Do you have problems chewing bagels or gum?
- YES NO Have your teeth changed in the last five years?
- YES NO Do you have more than one bite?
- YES NO Do you sleep restlessly?

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a removable partial or complete denture, please complete the following:

YES NO Has your present denture been relined?
When? _____

YES NO Is your present denture a problem?
Describe: _____

YES NO Are you satisfied with the appearance? _____

YES NO Are you satisfied with the comfort?

YES NO Are you satisfied with the chewing ability? _____

When did you receive your first partial or complete denture?

How long have you worn your present denture? _____

DOCTOR'S SIGNATURE: _____ **DATE:** _____

DOCTOR'S REMARKS: _____

