Dental Medical History Forms

DENTAL HISTORY FORM

Patient's full name: _____ **Patient's ID#:** _____

Attending dentist's full name: _____ **Date submitted:** _____ dd / mm / yyyy

Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care. All information will be kept completely confidential.

What is the reason for your visit today?

Date of last dental visit: _____ dd / mm / yyyy **Last dental cleaning date:** _____ dd / mm / yyyy

Last full-mouth X-ray date: _____ dd / mm / yyyy

What was done during your last dental visit?

Previous dentist's name: _____ **Contact number:** _____

Address (including state and zipcode): _____ **How often do you have dental exami...** _____

How often do you brush your teeth?: _____ **How often do you floss?:** _____

Have you ever used or are you currently using topical fluoride?

◯ Yes ◯ No

What dental aids do you use (e.g., Interplak, toothpicks, etc.)?

Do you have any dental problems right now?

◯ Yes ◯ No

If yes, please describe:

Are any of your teeth sensitive to hot and cold?

◯ Yes ◯ No

Are any of your teeth sensitive to sweets?

◯ Yes ◯ No

Are any of your teeth sensitive to biting or chewing?

◯ Yes ◯ No

Have you noticed any mouth odors or bad taste?

◯ Yes ◯ No

Do you frequently get cold sores, blisters or any other oral lesions?

◯ Yes ◯ No

Do your gums bleed or hurt?

◯ Yes ◯ No

Have your parents experienced gum disease or tooth loss?

◯ Yes ◯ No

Have you noticed any loose teeth or change in your bite?

◯ Yes ◯ No

Does food tend to become caught in between your teeth?

◯ Yes ◯ No

If yes, where?

Have you ever had orthodontic treatment?

◯ Yes ◯ No

Have you ever had oral surgery?

◯ Yes ◯ No

Have you ever had periodontal treatment?

◯ Yes ◯ No

Have you ever had your teeth ground or the bite adjusted?

◯ Yes ◯ No

Have you ever had a bite plate or mouth guard?

◯ Yes ◯ No

Have you ever had a serious injury to the mouth or head?

◯ Yes ◯ No

If yes, please describe, including cause:

Do you clench or grind your teeth while awake or asleep?

◯ Yes ◯ No

Do you bite your lips or cheeks regularly?

◯ Yes ◯ No

Do you hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)?

◯ Yes ◯ No

Do you mouth breathe while awake or asleep?

◯ Yes ◯ No

Do you have tired jaws, especially in the morning?

◯ Yes ◯ No

Do you snore or have any other sleeping disorders?

◯ Yes ◯ No

Do you smoke/chew tobacco or use other tobacco products?

◯ Yes ◯ No

Have you experienced clicking or popping of the jaw?

◯ Yes ◯ No

Have you experienced pain (joint, ear, side of face)?

◯ Yes ◯ No

Have you experienced difficulty in opening or closing the mouth?

◯ Yes ◯ No

Have you experienced difficulty in chewing on either side of the mouth?

◯ Yes ◯ No

Have you experienced headaches, neck aches or shoulder aches?

◯ Yes ◯ No

Have you experienced sore muscles (neck, shoulders)?

◯ Yes ◯ No

Are you satisfied with your teeth's appearance?

◯ Yes ◯ No

Would you like to keep all of your teeth all of your life?

◯ Yes ◯ No

Do you feel nervous about having dental treatment?

◯ Yes ◯ No

If so, what is your biggest concern?

Have you ever had an upsetting dental experience?

◯ Yes ◯ No

If yes, 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:

MEDICAL HISTORY FORM

Have you had any medical care within the past two years?

◯ Yes ◯ No

If yes, please describe:

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

◯ Yes ◯ No

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

◯ Yes ◯ No

Have you ever taken prescription medications for weight loss (diet pills)?

◯ Yes ◯ No

If yes, did you take any of the following?

☐ Fen-Phen

☐ Pondimen

☐ Redux

☐ Other

If you ticked any options in the previous question, did you have a medical exam for heart issues?

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

◯ Yes ◯ No

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

◯ Yes ◯ No

If yes, please specify:

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

◯ Yes ◯ No

Heart (surgery, disease, attack):

◯ Yes ◯ No

Chest pain:

◯ Yes ◯ No

Congenital heart disease:

◯ Yes ◯ No

Heart murmur:

◯ Yes ◯ No

High/low blood pressure:

◯ Yes ◯ No

Artificial heart valve/pacemaker:

◯ Yes ◯ No

Rheumatic fever:

◯ Yes ◯ No

Arthritis/rheumatism:

◯ Yes ◯ No

Cortisone medicine:

◯ Yes ◯ No

Swollen ankles:

◯ Yes ◯ No

Stroke:

◯ Yes ◯ No

Diet (special/restricted):

◯ Yes ◯ No

Artificial joints (hip, knee, etc.):

◯ Yes ◯ No

Kidney trouble:

◯ Yes ◯ No

Ulcers:

◯ Yes ◯ No

Diabetes:

◯ Yes ◯ No

Thyroid problems:

◯ Yes ◯ No

Glaucoma:

◯ Yes ◯ No

Contact lenses:

◯ Yes ◯ No

Emphysema:

◯ Yes ◯ No

Chronic cough:

◯ Yes ◯ No

Tuberculosis:

◯ Yes ◯ No

Asthma:

◯ Yes ◯ No

Hay fever/allergy/hives:

◯ Yes ◯ No

Latex sensitivity:

◯ Yes ◯ No

Sinus trouble:

◯ Yes ◯ No

Radiation therapy:

◯ Yes ◯ No

Chemotherapy:

◯ Yes ◯ No

Tumors:

◯ Yes ◯ No

Hepatitis (A, B, or C):

◯ Yes ◯ No

Venereal disease:

◯ Yes ◯ No

AIDS/HIV positive:

◯ Yes ◯ No

Cold sores/fever blisters:

◯ Yes ◯ No

Blood transfusion:

◯ Yes ◯ No

Hemophilia:

◯ Yes ◯ No

Sickle cell disease:

◯ Yes ◯ No

Bruise easily:

◯ Yes ◯ No

Liver disease/yellow jaundice:

◯ Yes ◯ No

Neurological disorders:

◯ Yes ◯ No

Epilepsy or seizures:

◯ Yes ◯ No

Fainting or dizzy spells:

◯ Yes ◯ No

Nervous/anxious:

◯ Yes ◯ No

Psychiatric/psychological care:

◯ Yes ◯ No

Have you lost or gained more than 10 pounds in the last year?

◯ Yes ◯ No

For women only: Are you pregnant or think you could be pregnant?

◯ Yes ◯ No

If yes, how many months have you been pregnant (whether you think it or if yo... _____

Are you nursing?

◯ Yes ◯ No

Do you use birth control prescriptions?

◯ Yes ◯ No

I understand the above information in 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's signature:
Date signed: _____ dd / mm / yyyy

Parent/guardian's signature (if the patient is a minor):
Date signed: _____ dd / mm / yyyy

Attending dentist's signature:
Date signed: _____ dd / mm / yyyy