

Patient name
Medical Alert

*Welcome! So that we may provide you with the best possible care please complete both pages of this medical/dental history form.
All information is completely confidential.*

Dental History

What is the reason for your visit today? _____

Date of Last visit _____ **Date last dental cleaning** _____ **Last Full Mouth X-rays** _____
 What was done at your last dent visit? _____

Previous Dentist name? _____
 Address _____
 Telephone _____

How often do you have dental examinations?
 How often do you brush your teeth? _____ How often do you floss? _____
 What other dental aids do you use? (Interplak, toothpick, Sonicare, etc.) _____

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

Are any of your teeth sensitive to:

Hot or cold? Yes No
 Sweets? Yes No
 Biting and chewing? Yes No
 Have you noticed any mouth odors or bad tastes? Yes No
 Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Have you ever had:

Orthodontic treatment? Yes No
 Oral Surgery? Yes No
 Periodontal treatment? Yes No
 Your teeth ground or the bite adjusted? Yes No
 A bite plate or mouth guard? Yes No
 A serious injury to the mouth or head? Yes No
 If so, please describe, including cause _____

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 experienced:

Clicking or popping of the jaw? Yes No
 Pain? (neck, shoulders)? Yes No
 Difficulty in chewing on either side of the mouth? Yes No
 Difficulty in opening or closing the mouth? Yes No
 Headaches, neck-aches or shoulder aches? Yes No
 Sore Muscles (neck, shoulders)? Yes No

Do You:

Clench or grind your teeth while awake or asleep? Yes No
 Bite your lips or cheeks regularly? Yes No
 Hold foreign objects with your teeth? Yes No
 (pencils, pipe, pins, nails, fingernails)
 Mouth breath while awake or asleep? Yes No
 Have tired jaws, especially in the morning? Yes No

Are you satisfied with your smile? 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: _____

Is there anything else about having dental treatment that you would like us to know?
 If yes, please describe: _____

2. Do you use more than two pillows to sleep? Yes No
3. Have you lost or gained more than 10 pounds in the last year? Yes No
4. Have you ever taken prescription medications for weight loss (diet pills)? Yes No
5. Have you taken any of the following drugs within the last 24 hours Cocaine, Ecstasy or Methamphetamine? Yes No
6. Do you have a history of Chemical dependency? Yes No
If yes, how long have you been in recovery? _____
7. Are you currently taking any medication for osteoporosis (bone loss)? Yes No

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

- | | | | | | | | | |
|--|-----|----|--------------------------|-----|----|------------------------------------|-----|----|
| Heart (Surgery, Disease, Attack)..... | Yes | No | Ulcers..... | Yes | No | Hepatitis A (infectious) B (serum) | Yes | No |
| Chest Pain..... | Yes | No | Diabetes..... | Yes | No | Venereal Disease..... | Yes | No |
| Congenital Heart Disease..... | Yes | No | Thyroid Problems..... | Yes | No | A.I.D.S..... | Yes | No |
| Heart Murmur..... | Yes | No | Glaucoma..... | Yes | No | H.I.V. Positive..... | Yes | No |
| High Blood Pressure..... | Yes | No | Do you take Viagra?..... | Yes | No | Cold Sores/Fever Blisters..... | Yes | No |
| Mitral Valve Prolapse..... | Yes | No | Emphysema..... | Yes | No | Blood Transfusion..... | Yes | No |
| Artificial Heart Valve..... | Yes | No | Chronic Cough..... | Yes | No | Hemophilla..... | Yes | No |
| Heart Pacemaker..... | Yes | No | Tuberculosis..... | Yes | No | Sickle Cell Disease..... | Yes | No |
| Rheumatic Fever..... | Yes | No | Asthma..... | Yes | No | Bruise Easily..... | Yes | No |
| Arthritis/Rheumatism..... | Yes | No | Hay Fever..... | Yes | No | Liver Disease..... | Yes | No |
| Cortisone Medicine..... | Yes | No | Latex Sensitivity..... | Yes | No | Yellow Jaundice..... | Yes | No |
| Swollen Ankles..... | Yes | No | Allergies or Hives..... | Yes | No | Neurological Disorders..... | Yes | No |
| Stroke..... | Yes | No | Sinus Trouble..... | Yes | No | Epilepsy or Seizures..... | Yes | No |
| Diet (Special/Restricted)..... | Yes | No | Radiation Therapy..... | Yes | No | Fainting or Dizzy Spells..... | Yes | No |
| Artificial Joints (hip, knee, etc.)..... | Yes | No | Chemotherapy..... | Yes | No | Nervous/Anxious..... | Yes | No |
| Kidney Trouble..... | Yes | No | Tumors..... | Yes | No | Psychiatric/Psychological Care.. | Yes | No |
8. Have you been hospitalized or under the care of a medical doctor during the past two years? Yes No
If yes, for what? _____
Physician's Name _____ Phone # _____
9. Are you taking any medication, drugs or pills now, including regular dosages of aspirin? Yes No
If yes, please list name and dosage. _____
10. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
11. Do you have or have you had any disease, condition, or problem not listed? Yes No
If yes, please list. _____

12. Women. Are you: Pregnant? Yes No Months _____ Nursing? Yes No
Taking Birth Control pills? Yes No _____

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 changes in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review	
PREMED	MEDICAL ALERT
Dentist Signature _____	Date _____