Medical History

Patient Name:... _

Current Medications /dose

Medication Allergies

Circle

1.Where are you having any pain or discomfort at this time? ....
....
2.Have you been a patient in the **hospital** during the past two years? .... YES NO
3.Have you been under the **care of a medical doctor** during the past two years? .... YES NO
4.Have you taken **medicine or drugs** during the past two years? .... YES NO
5.Are you **allergic to** (Le. itching, rash, swelling of hands, feet or eyes) or made sick
by **penicillin, aspirin, codeine or any drugs or medications**? ...list below ....YES NO
6.Have you ever had **excessive bleeding** or been on **Blood Thinners**... .... YES NO
7.When you walk up stairs or take a walk, do you ever have to stop because of **pain**
in your chest, or shortness of breath, or because you are very tired? .... YES NO
8.Do you **ankles swell** during the day? ....: .... YES NO
9.Are you a **smoker** and How much per day? .... YES NO
10.Have you **lost or gained** more than 10 pounds in the past year? .... YES NO
11.Do you ever **wake up from sleep short of breath**? .... YES NO
12.Are you on a **special diet**? ....YES NO
13.Do you have a history of **recreational drugs or drug abuse**?.....................................YES NO
13.Has your medical doctor ever said you have a **cancer or tumor**? ....YES NO
14.Women: Are you **pregnant** now? ....YES NO
Do you anticipate becoming pregnant? ....YES NO

15. **Circle Yes** or **No** for each and every of the following which you have had or have at present:

Condition		Condition		Condition	
Heart Failure	**Yes No**	Emphysema	**Yes No**	AIDS	**Yes No**
Heart Disease or Attack	**Yes No**	Cough	**Yes No**	Hepatitis (infectious)	**Yes No**
Angina Pectoris	**Yes No**	Tuberculosis (TB	**Yes No**	Hepatitis (serum)	**Yes No**
High Blood Pressure	**Yes No**	Asthma	**Yes No**	Liver Disease	**Yes No**
Heart Murmur	**Yes No**	Hay Fever	**Yes No**	Yellow Jaundice	**Yes No**
Rheumatic Fever	**Yes No**	Sinus Trouble	**Yes No**	Blood Transfusion	**Yes No**
Congenital Heart Lesions	**Yes No**	Allergies or Hives	**Yes No**	Drug Addiction	**Yes No**
Scarlet Fever	**Yes No**	Diabetes	**Yes No**	Hemophilia	**Yes No**
Artificial Heart Valve	**Yes No**	Thyroid Disease	**Yes No**	Venereal Disease	**Yes No**
Heart Pacemaker	**Yes No**	Radiation Treatment	**Yes No**	Cold Sores	**Yes No**
Heart Surgery	**Yes No**	Chemotherapy	**Yes No**	Genital Herpes	**Yes No**
Artificial Joint	**Yes No**	Arthritis	**Yes No**	Epilepsy or Seizures	**Yes No**
Anemia	**Yes No**	Rheumatism	**Yes No**	Fainting/Dizzy Spells	**Yes No**
Stroke	**Yes No**	Cortisone Medicine	**Yes No**	Nervousness	**Yes No**
Kidney Trouble	**Yes No**	Glaucoma	**Yes No**	Psychiatric Treatment	**Yes No**
Ulcers	**Yes No**	Pain in Jaw Joints	**Yes No**	Bruise Easily	**Yes No**

16. Please write if have or had any disease, condition, or problem not listed ____
____
Date of last Complete Physical incl. blood tests:____________Problems Observed ____________________________________

Physicians Name:____________________________ Medical Grp:_____________________________ Phone ________________

Specialist:__________________________________ Medical Grp:_____________________________ Phone ________________

Specialist:__________________________________ Medical Grp:_____________________________ Phone ________________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicineschange, I will inform the dentist at the next appointment with fail. Changes may also be faxed, phoned, or emailed to the dentist as well.

_____________ _________________________________ ____
Date Dentists Signature Signature of Patient, Parent or Guardian

Do Not Write In This Area **Medical History / Physical Evaluation Update** **Doctor Only**

Date	Addition	Date	Addition
______	______________________________________	______	____
______	______________________________________	______	____
______	______________________________________	______	____
______	______________________________________	______	____
______	______________________________________	______	____
______	______________________________________	______	____

Dental Health History Please answer only those questions that apply, if not sure of your answer, place "**?**" and discuss w/ Dr.

Reason for visit: ____

Date of last dental visit? ______________What was done?____

Former Dentist Name, Address, and Phone:____

Current or Recent Dental Specialists Name and phone:____

Last Full Mouth Xrays_______________(full set =14+ xrays) Digital - Yes No Last Cleaning appt? _________ How Often?_________

Last Deep Scaling for gum disease:__________________By Whom?______________________ Last Gum Surgery? ________________

Additional Notes:____

What do you **NOT** like about the appearance of your smile?_________________________________

What would you like to change about your smile?____

When did you last whiten your teeth?___________How Often do you touch up whiten?________Brand of Whitener? _________________

Additional Notes:____

When did you have Orthodontic (Braces) Treatment? __________________Years in Treatment? ____________Retainers worn?________

Orthodontist Name and info: ____

When did you have the following:

Head or Neck Injury such as fall or car accident?__________________________ Treatment?___________________________________

Jaw or teeth injuries?_____________________ Treatment? ____

How do you still suffer from these injuries? ____

Continued treatment? ____

Dental Anxiety and Fear:

How does Dental treatment make you nervous? ____

What bad experiences or problems have you had at the dentist? _____________________________________

What helps make you more comfortable when going to the dentist? ___________________________________

Have you ever had a bad reaction to dental anesthetic? Please describe: _______________________________

Oral hygiene Habits: please be accurate

When do you brush your teeth?_______________ What type of brush do you use? (circle) Manual or Electric / Brand name?___________

When do you **floss**?________________Brand name? ______________ Do your gums bleed.., when brushing? _____when flossing? _____

What areas do you avoid when brushing or flossing? __________________________Why? ____

WHERE do you have PAIN with the following? :

HOT FOODS OR LIQUIDS? ____ Circle: Sharp Dull Achey Pain lingers

How often does this occur?________________________ What makes it feel better?__________________________

COLD FOODS OR LIQUIDS? ____ Circle: Sharp Dull Achey Pain lingers

How often does this occur?________________________ What makes it feel better?__________________________

SWEETS OR SOUR? ____ Circle: Sharp Dull Achey Pain lingers

How often does this occur?________________________ What makes it feel better?__________________________

Where do you have pain on BITE PRESSURE?______________________________ Circle: Sharp Dull Achey Pain lingers

How often does this occur?___________________Which side do you chew on?_______________ Why? _________________________

Where are your gums tender or swollen? ____

When you do clench or grind your teeth? _______________________When do your jaws feel tired? ______________________________

Do you wear a bite guard? Yes No When? _______________ Type of Guard? ______________ How Often? ___________________

Do you have many cavities? Yes No Do you lose or break fillings? Yes No Do you gag easily? Yes No

What does the term preventive dentistry mean to you? ____

PARTIAL and FULL DENTURES Info:

Age of Partial or Full Dentures? UPPER Year Placed?________________ Last relined? ______________ Any repairs? ______________

___________________________ Problems you feel? ____

LOWER Year Placed?_______________ Last relined? ________________ Any repairs? _________________________

Problems you feel? ____

Please add any dental or mouth problems you are concerned about:

____

____

____

Additional Dental History Notes : ____

____

____

____

Date: Patient or Guardian Signature: