DENTAL PROFESSIONALS

Date ________________

MEDICAL HISTORY

for

Name ____ DOB ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a medical doctor's care now?	Yes	No	If yes, please explain: ________________
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: ________________
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: ________________
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: ________________
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	________________
Are you on a special diet?	Yes	No	________________
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Women: Are you

Pregnant/Trying to get pregnant? Yes No   Taking oral contraceptives? Yes No   Nursing? Yes No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics

❑ Other If yes, please explain: ________________

Do you have, or have you had, any of the following?

Condition			Condition			Condition			Condition		
AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: ________________

Comments: ____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ______________

______________________________ ______________

______________________________ ______________

______________________________ ______________

DENTAL INFORMATION

How long since your last Dental Exam? ___________Main reason for visit today? ____

Previous Dentist ____Address ____

Have you ever had any serious problems associated with previous Dental Treatment?_______________________________________

Pharmacy Name____Pharmacy Phone # _____________________________

Does Dental Treatment make you nervous? No __________Slightly________Moderately_________Extremely ________

How do you rate the current health of your mouth? Excellent Good Fair Poor

On a scale of 1-10 (10 being the highest),what priority do you put on the health of your mouth? 1 2 3 4 5 6 7 8 9 1 0

Are you happy with the appearance of your teeth? ____

Have you ever had

Past	Present	Never		Past	Present	Never	
							Bite Plate or Guard
			Frequent blisters / cold sores				Sensitivity to cold
			Food trapping				Sensitivity to hot
			Swelling or lump in mouth				Sensitivity to sweets
			Clicking / popping jaw				Sensitivity to biting
			Clenching / grinding of teeth				Loose teeth
			Discomfort in jaw joint				Periodontic Treatment
			Recurrent earaches or headaches				Bleeding or sore gums
			Orthodontics (Braces)				Unpleasant taste / bad breath
			Treatment Completed __________Year				Acid Reflux
							Oral Surgery
			Serious injury to mouth or head				

Do you use the following?

	Yes	No	**How Often?**		Yes	No	**How Often?**
Brush			_________________	Fluoride rinse			_______________
Floss			_________________	Mouthwash			_______________
Irrigator (Water Pick)			_________________	Tooth picks (Stimudent)			_______________
Soda			_________________				

Is there anything else about your mouth that you would like us to know about? ____

Infant/Toddler Questionnaire

Does your child take a bottle/sippy cup to bed at bedtime or naptime? Yes No

What kind of toothpaste does your child use? ____

Does it have fluoride in it? Yes No Does your child spit out or swallow the toothpaste? Yes No

Does your child have any oral habits?

Thumb/finger sucking Yes No Pacifier Yes No Other _______________________

Was your child breast fed or bottle fed? Yes No At what age was he/she weaned to solid foods _________________

Child Questionnaire

When does your child brush his/her teeth? Upon Arising _________ After meals__________ Before going to bed __________

How does your child receive fluoride? Community water_____ppm ______________ Fluoride drops/tablets________________

Well water_____ppm _____________________ Fluoride toothpaste/rinse/gel_________

Does your child eat between meals? Yes No

Does your child eat sweets, such as candy, soda, or chewing gum? Yes No

Does your child have a history of tooth decay? Yes No

Has your child had any injuries to his/her teeth, resulting in fractures, sensitivity, or discoloration? Yes No

Has your child had any or the following dental treatment done in the past? Sealants_____ Fillings______ Extractions ______

Has your child had any behavioral problems with past dental treatment? Yes No

How do you think your child will behave today? ____

Is there anything else about your child's teeth/mouth that you'd like us to know about? ____________________________________

Additional medical questions

Does your child have enlarged tonsils? Yes No Is your child a mouthbreather? Yes No

Does your child have an allergy to latex? Yes No Does your child have ADHD? Yes No