MEDICAL – DENTAL HISTORY

1. PERSONAL INFORMATION

Name ______________________________ Sex ________ Birth date ________________
Street Address ______________________________ PO Box ________________
City ______________________________ Postal Code ________________
Home Phone ________________ Cell Phone ________________ Business Phone ____________
Email ____
Care Card ____________________________ Physician's Name ________________________
How did you hear about our office? ____

2. MEDICAL HISTORY

Yes **No** 1. Has there been any change to your general health in the past year?
Yes **No** 2. Are you currently under the care of a physician?
Yes **No** 3. Have you had a medical exam in the past year?
Yes **No** 4. Are you currently taking any medications?
If yes, what? ____
Yes **No** 5. Have you ever had a serious illness or have you ever been hospitalized?
If yes, for what? ____
Yes **No** 6. Have you ever had or been treated for (please circle)

Heart trouble or stroke **Coronary artery disease** **Congenital heart disease**
Hypertension (high blood pressure) **Angina** **Heart murmur**
Rheumatic fever **Rheumatic heart disease** **Thyroid disease**
Stomach or intestinal ulcers **Jaundice** **Hepatitis or liver disease**
Venereal disease/ AIDS **Gastrointestinal disease** **Diabetes**
Epilepsy **Gall bladder** **Tuberculosis or lung disease**
Arthritis or rheumatism **Cancer** **Anemia**
Blood disorders **Kidney Disease** **Mental or nervous disease**
Injury to face or jaws **Injury to neck ie. Whiplash** **Growth or tumor**
Sleep disorders/Sleep apnea

Yes **No** 7. Do you have asthma, hay fever, hives, or skin rash?
Yes **No** 8. Are you allergic to anything?
If yes, please list: ____
Yes **No** 9. Are you allergic to any medicines? Such as penicillin, asprin, codeine?
If yes, Please list: ____
Yes **No** 10. Have you ever experienced fainting, shortness of breath, chest pains or swollen ankles?
Yes **No** 11. Has your weight changed lately?
Yes **No** 12. Has there been any change in your appetite or diet?
Yes **No** 13. Do you bruise easily?
Yes **No** 14. When injured, do you bleed excessively?
Yes **No** 15. Do you heal easily and normally?
Yes **No** 16. Has your tolerance to hot and cold been normal?
Yes **No** 17. Are you a smoker?
Yes **No** 18. Have you ever had radiation or cobalt therapy?
Yes **No** 19. Do you have any prosthetic appliances?
Yes **No** 20. Women – Are you pregnant?
If yes, In what stage or term of pregnancy? ______________________________
Yes **No** 21. Is there anything that the dentist should know regarding your medical history that has not been mentioned?
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3. DENTAL HISTORY

Yes **No** 1. Have you been under the regular care of a dentist?
If yes, Whom?____last Visit?______________________

Yes **No** 2. Do any of your teeth ache?
Yes **No** 3. Do your gums bleed or feel tender/swollen?
Yes **No** 4. Do you notice a bad taste or odor in your mouth?
Yes **No** 5. Do you have sensitive teeth?
Yes **No** 6. Does food catch between your teeth?
Yes **No** 7. Do you have any loose teeth?
Yes **No** 8. Do your jaw joints get sore?
Yes **No** 9. Do you notice a click or popping noise on opening or closing in your jaw joint?
Yes **No** 10. Do you frequently bite your tongue, cheeks or lips?
Yes **No** 11. Do you experience frequent headaches?
Yes **No** 12. Do you find yourself clenching your teeth?
Yes **No** 13. Do you have dental anxiety?
If yes, please explain. ____
Yes **No** 14. Do you like the appearance of your teeth? If not, what is it you don't like about them?
____

15. How **frequently** do you brush? ____
16. How **frequently** do you use dental floss?____
17. Please describe your present problem and/or complaint_______________________________
____
____
18. Any other information you would like the Doctor or Hygienist to be aware of? ______________
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PLEASE NOTE THAT ANY CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO THE OFFICE AT THE EARLIEST POSSIBLE TIME

SIGNATURE ____ **TODAYS DATE** ______________________