NAME OF THE PATIENT:_____ DATE OF BIRTH:_____

MEDICAL HEALTH HISTORY

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

Cancer or tumor	❑ yes	❑ no
Heart ailment or angina	❑ yes	❑ no
Heart murmur, mitral valve prolapse, heart defect	❑ yes	❑ no
Rheumatic fever or rheumatic heart disease	❑ yes	❑ no
Artificial joint or valve	❑ yes	❑ no
High or low blood pressure	❑ yes	❑ no
Pacemaker	❑ yes	❑ no
Tuberculosis or other lung problems	❑ yes	❑ no
Kidney disease	❑ yes	❑ no
Hepatitis or other liver disease	❑ yes	❑ no
Hyperthyroid / Hypothyroid	❑ yes	❑ no
Blood transfusion	❑ yes	❑ no
Diabetes	❑ yes	❑ no
Neurologic condition	❑ yes	❑ no
Epilepsy, seizures, or fainting spells	❑ yes	❑ no
Emotional condition	❑ yes	❑ no
Arthritis	❑ yes	❑ no
Herpes or cold sores	❑ yes	❑ no
AIDS or HIV positive	❑ yes	❑ no
Migraine headaches or frequent headaches	❑ yes	❑ no
Anemia or blood disorders	❑ yes	❑ no
Abnormal bleeding after extractions, surgery, or trauma	❑ yes	❑ no
Hayfever or sinus trouble	❑ yes	❑ no
Allergies or hives	❑ yes	❑ no
Asthma	❑ yes	❑ no
Do you smoke or use chewing tobacco?	❑ yes	❑ no

Are you allergic to, or have you reacted adversely to any of the following?

• Latex (Rubber) materials	❑ yes	❑ no
• Penicillin or other antibiotics	❑ yes	❑ no
• Local anesthetics ("Novocaine")	❑ yes	❑ no
• Codeine or other narcotics	❑ yes	❑ no
• Sulfa drugs	❑ yes	❑ no
• Barbiturates, sedatives, or sleeping pill	❑ yes	❑ no
• Aspirin	❑ yes	❑ no

Other:_____

Are you taking any of the following?

• Aspirin	❑ yes	❑ no
• Anticoagulants (blood thinners)	❑ yes	❑ no
• Antibiotics or sulfa drugs	❑ yes	❑ no
• High blood pressure medicine	❑ yes	❑ no
• Antidepressants or tranquilizers	❑ yes	❑ no
• Insulin, Orinase, or other diabetes drug	❑ yes	❑ no
• Nitroglycerin	❑ yes	❑ no
• Cortisone or other steroids	❑ yes	❑ no
• Osteoporosis (bone density) medicine	❑ yes	❑ no

Other: _____

Women:

May be pregnant	❑ yes	❑ no
Expected delivery date: _____		
Taking hormones or contraceptives	❑ yes	❑ no

Do you have any disease, condition, or problem not listed above?_____

Name and phone number of your primary care physician:_____

********** Please turn over for more information **********

NAME OF THE PATIENT:_____ DATE OF BIRTH:_____

DENTAL HEALTH HISTORY

Are you concerned about having dental treatment ❑ yes ❑ no
Have you have problems with previous dental treatment ❑ yes ❑ no
Do you gag easily ❑ yes ❑ no
Does food catch between your teeth ❑ yes ❑ no
Do you have difficulty chewing your food ❑ yes ❑ no
Do you chew on only one side of your mouth ❑ yes ❑ no
Do you avoid brushing any part of your mouth because of pain ❑ yes ❑ no
Do your gums bleed easily ❑ yes ❑ no
Do your gums bleed when you floss ❑ yes ❑ no
Do your gums feel swollen or tender ❑ yes ❑ no
Have your ever noticed slow-healing sores in your mouth ❑ yes ❑ no
Are your teeth sensitive ❑ yes ❑ no
Do you feel twinges of pain when your teeth come in contact with:
- Hot foods or liquids ❑ yes ❑ no
- Cold foods or liquids ❑ yes ❑ no
- Sours ❑ yes ❑ no
- Sweets ❑ yes ❑ no

Do you take fluoride supplements ❑ yes ❑ no
Are you dissatisfied with the appearance of your teeth ❑ yes ❑ no
Do you want complete dental care ❑ yes ❑ no

Does your jaw make noise so that it bothers you or others ❑ yes ❑ no
Do you clench or grind your jaws frequently ❑ yes ❑ no
Do your jaws every feel tired ❑ yes ❑ no
Does your jaw get stuck so that you can't open feel ❑ yes ❑ no
Does it hurt when you chew or open wide to take a bite ❑ yes ❑ no
Do you have earaches or pain in front of the ears ❑ yes ❑ no
Do you have any jaw symptoms or headaches upon waking in the morning ❑ yes ❑ no
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities ❑ yes ❑ no
Do you find jaw pain or discomfort extremely frustrating or depressing ❑ yes ❑ no
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants) ❑ yes ❑ no
Do you have temporomandibular (jaw) disorder (TMD ❑ yes ❑ no
Have you have a blow (trauma) to your jaw ❑ yes ❑ no
Are you a habitual gum chewer ❑ yes ❑ no

Please elaborate on any of the questions above that you might have answered "yes":_____

_____

When was your last visit to the dentist ?_____

Did you have any treatment needs at your last dental check up ? If yes, was the treatment finished ?

_____

Do you have any dental concerns not listed above?_____

I understand the importance of being truthful about my dental history and realize that incomplete information may have an adverse (negative) effect on my treatment and possibly my health. To the best of my knowledge, the information above is complete and accurate.

Signature of patient _____ Date _____

Printed Name of patient _____

Dentist's Signature: _____