MEDICAL HISTORY

WELCOME! So that we may provide you with the best possible care, please complete this medial/dental history form. All information is completely confidential.

PATIENT NAME: ____MEDICAL ALERTS: _____________________

REASON FOR TODAY'S VISIT:_________________________WHEN WERE DENTAL XRAYS LAST TAKEN:_______________________

Has there been any problem with your general health within the past year? ____Yes ____No

If so, what was the problem?____

Are you under a physician's care now? ____Yes ____No If so, for what?_______________________________________

Physician's name:___________________________________Phone #: ____

Have you ever been hospitalized for any serious illness or surgical operation? ____Yes ____No Please explain:

Please list all medicines, including prescription, non-prescription and herbal remedies that you are taking:

____

Have you taken any medications in the past year? ____ Yes ____No If so, what?________________________________

Are you allergic to or have you had adverse reactions to the following: ___Penicillin ___Aspirin ___Codeine ___Anesthetics ___Latex

Other: ____

__________No Known Drug Allergies

Do you Pre-Medicate for dental appointments? ____YES ____NO If yes, what medication do you Pre-Medicate with? __________________________

Do you use tobacco? ____Yes ____No Please explain______________________ Do you use Alcohol _______ Cocaine ____ other drugs?

Please explain: ________________________________

Do you have or have you ever had the following:

Condition	Y/N	Condition	Y/N
Rheumatic fever, rheumatic heart disease	___Y___N	Joint replacement or implants	___Y___N
Heart defect or heart murmur	___Y___N	Lung or breathing problems	___Y___N
Heart trouble, heart attack or angina	___Y___N	Tuberculosis	___Y___N
Pain in your chest on exertion	___Y___N	Asthma	___Y___N
Short of breath after mild exercise	___Y___N	Sinus troubleY	___Y___N
Ankles swelling	___Y___N	Allergies	___Y___N
Shortness of breath when lying down	___Y___N	Hives or skin rash	___Y___N
Require extra pillows when you sleep	___Y___N	Fainting spells or seizures	___Y___N
Pacemaker	___Y___N	Thyroid problems	___Y___N
Mitral Valve prolapse	___Y___N	Psychiatric/ psychologic care	___Y___N
Heart surgery	___Y___N	Arthritis or rheumatism	___Y___N
High blood pressure	___Y___N	AIDS	___Y___N
Low blood pressure	___Y___N	HIV Positive	___Y___N
Hepatitis, jaundice or liver disease	___Y___N	Persistent cough	___Y___N
Bleeding disorder	___Y___N	Cough that produces blood	___Y___N
Stroke	___Y___N	Stomach ulcer	___Y___N
Diabetes	___Y___N	Kidney trouble	___Y___N
Cancer	___Y___N	Sexually transmitted disease	___Y___N
Leukemia	___Y___N	Glaucoma	___Y___N
Cosmetic or Medical implant	___Y___N		

WOMEN: Are you PREGNANT?___Yes___No _____Months NURSING? __YES ___No

TAKING BIRTH CONTROL PILLS? ___Yes___No

DO YOU CURRENTLY, OR HAVE YOU EVER TAKEN FOSAMAX? ____ YES ____NO

DO YOU GET MIGRAINE HEADACHES: YES NO Frequency? __________________ Severity _______________________

DO YOU HAVE ANY DISEASE, PROBLEM OR CONDITION NOT LISTED? ____Yes ____No Please explain:_____________________________

DENTAL HEALTH HISTORY : Part 2 of HEALTH HX

DO YOU HAVE ANY AREAS IN YOUR MOUTH THAT CONCERN YOU NOW? Yes No If so, please explain

1. Circle if any areas of your teeth sensitive to:
   Hot cold sweets pressure (chewing)

2. Have you ever had Oral or Periodontal surgery? No Yes
3. Have you ever had your bite adusted? No Yes

4. Have you ever had a Nightguard or other appliance? No Yes

5. Have you noticed

loosening/shifting of your teeth	No Yes
food catching between your teeth	No Yes
pain/swelling of your gums	No Yes
gums bleeding when you brush or floss	No Yes
bad breath/taste/odor of mouth	No Yes
sore areas in mouth	No Yes

6. Have you ever been told you have periodontal disease, or gum disease? No Yes

7. Have you ever experienced

Clicking of the jaw	No Yes
Pain in the joint, ear, side of face	No Yes
Difficulty opening/closing the mouth	No Yes
Difficulty chewing	No Yes
Frequent headaches	No Yes

8. Have you had any jaw, head, neck injuries? No Yes If yes, explain: ____

How often do you have dental examinations?________________________ When was your last dental exam? ____________________

When were your last dental Xrays taken: ________

How often do you brush your teeth?________________________________How often do you floss?

What other dental aids do you use? (Proxa Brush, toothpick, Water Irrigator, etc.)

What toothpaste do you use?

What mouthrinse?

What type of toothbrush do you use? Soft Medium Hard Electric

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge.

Patient/Guardian Signature____ Date:______________________________________