Patient Name	**MEDICAL HISTORY**
Patient Address	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medical drugs, or pills now (including vitamins)? Yes No
   If yes, please list name and dosage: _____
4. Have you ever taken prescription bisphosphonate medications? Yes No
   If yes, did you take the following: Fosamax Yes No
   Boniva Yes No
   Actonel Yes No
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
   If yes, please list: _____
6. Have you been a patient in the hospital during the past five years? Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	**Ulcers**	Yes	No	**Hepatitis A (infectious) B (serum)**	Yes	No
			Diabetes	Yes	No	**Venereal Disease**	Yes	No
Chest Pain	Yes	No	**Thyroid Problems**	Yes	No	**AIDS/HIV Positive**	Yes	No
Congenital Heart Disease	Yes	No	**Glaucoma**	Yes	No	**Alzheimer's Disease**	Yes	No
Heart Murmur	Yes	No	**Contact Lenses**	Yes	No	**Cold Sores/Fever Blisters**	Yes	No
High Blood Pressure	Yes	No	**Emphysema**	Yes	No	**Blood Transfusion**	Yes	No
Mitral Valve Prolapse	Yes	No	**Chronic Cough**	Yes	No	**Hemophilia/Bleeding Problems**	Yes	No
Artificial Heart Valve	Yes	No	**Tuberculosis**	Yes	No	**Sickle Cell Disease**	Yes	No
Heart Pacemaker	Yes	No	**Asthma**	Yes	No	**Bruise Easily**	Yes	No
Rheumatic Fever	Yes	No	**Hay Fever**	Yes	No	**Liver Disease**	Yes	No
Arthritis/Rheumatism	Yes	No	**Latex Sensitivity**	Yes	No	**Yellow Jaundice**	Yes	No
Cortisone Medicine	Yes	No	**Allergies or Hives**	Yes	No	**Neurological Disorders**	Yes	No
Swollen Ankles	Yes	No	**Sinus Trouble**	Yes	No	**Epilepsy or Seizures**	Yes	No
Stroke	Yes	No	**Radiation therapy**	Yes	No	**Fainting or Dizzy Spells**	Yes	No
Diet (Special/Restricted)	Yes	No	**Chemotherapy**	Yes	No	**Nervous/Anxious**	Yes	No
Artificial Joints (hip, knee, etc)	Yes	No	**Tumors/Malignancy**	Yes	No	**Psychiatric/Psychological Care**	Yes	No
Kidney Trouble	Yes	No	**Daily Aspirin**	Yes	No			

8. Do you use more than two pillows to sleep? Yes No
9. Have you lost or gained more than 10 pounds in the past year? Yes No
10. Do you have or have you had any disease, condition, or problem not listed? Yes No
    If yes, please list: _____
11. Women: Are you: Pregnant? Yes___ Months No Nursing? Yes No Taking birth control pills? Yes No
    Have you reached menopause: Yes No Do you take hormones? Yes No Calcium Supplements Yes No
12. Men: Are you: Taking medications for erectile dysfunction? Yes No If yes, please list_____

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 be best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature_____ Date_____

History Review

Dentist Signature_____ Date_____

Patient Name

DENTAL HISTORY

Welcome! *So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

What is your chief complaint? _____

Date of Last Dental Visit_____ **Last Dental Cleaning**_____**Last Full Mouth X-rays**_____

What was done at your last dental visit? _____

General Dentist Name _____Telephone_____

Address_____State_____Zip_____

How often do you have dental examinations?_____

How often do you brush your teeth? _____How often do you floss?_____

What other dental aids do you use? (Electric toothbrush, proxabrush, toothpick, etc.)_____

What type or brand of toothpaste do you use?_____ Mouth rinse? _____

Do you have any dental problems now? Yes No

If yes, please describe:_____

Who can we thank for referring you to our office? _____

Please answer each question:

Are any of your teeth sensitive to:		
Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sore, blisters or other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where?_____		

Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No
If so, how much_____		
Consume alcohol?	Yes	No
If so, how much _____		

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause_____ _____		

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern_____ _____		
Have you ever had a bad dental experience?	Yes	No
If yes, please describe_____ _____		

On a scale of 0 – 10, how important are your teeth to you? 1 2 3 4 5 6 7 8 9 10
(least) (most)

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

(Please complete other side)

M R