Patient Account No.

Medical Alert

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.

| dress lephone w often do you have dental examinations? w often do you brush your teeth? | | | | | |
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| w often do you brush your teeth? | | | | | |
| | | | | | |
| | | | How often do you floss? | | |
| nat other dental aids do you use? (Interplak, toothpic | k, etc.) | | | | |
| you have any dental problems now? yes, please describe: | | | | | |
| Are any of your teeth sensitive to: | | | Have you ever had: | | |
| Hot or cold? | Yes | No | Orthodontic treatment? | Yes | No |
| Sweets? | Yes | No | Oral surgery? | Yes | No |
| Biting or Chewing? | Yes | No | Periodontal treatment? | Yes | No |
| Have you noticed any mouth odors or bad tastes? Do you frequently get cold sores, blisters or | Yes | No | Your teeth ground or the bite adjusted? | Yes | No |
| any other oral lesions? | Yes | No | A bite plate or mouth guard? A serious injury to the mouth or head? | Yes Yes | No No |
| any other oral resions: | 103 | 140 | If so, please describe, including cause | 165 | 140 |
| Do your gums bleed or hurt? | Yes | No | | | |
| Have your parents experienced gum disease | | | | | |
| or tooth loss? | Yes | No | Have you experienced: | | |
| Have you noticed any loose teeth or change | | | Clicking or popping of the jaw? | Yes | No |
| in your bite? | Yes | No | Pain? (joint, ear, side of face) | Yes | No |
| Does food tend to become caught in between | Yes | No | Difficulty in opening or closing the mouth? Difficulty in chewing on either side of the mouth? | Yes Yes | No |
| If yes, where? | 165 | No | Headaches, neckaches or shoulder aches? | Yes | No No |
| 11 you, whole: | | | Sore muscles (neck, shoulders)? | Yes | No |
| Do you: | | | core massive (many enearester). | | - |
| Clench or grind your teeth while awake or asleep? | Yes | No | Are you satisfied with your teeth's appearance? | Yes | No |
| Bite your lips or cheeks regularly? | Yes | No | Would you like to keep all of your teeth all of your life? | Yes | No |
| Hold foreign objects with your teeth? | | | | | |
| (pencils, pipe, pins, nails, fingernails) | Yes | No | Do you feel nervous about having dental treatment? | Yes | No |
| Mouth breathe while awake or asleep? | Yes | No | If so, what is your biggest concern? | | |
| Have tired jaws, especially in the morning? Smoke/chew tobacco? | Yes Yes | No No | Have you ever had an upsetting dental experience? | Yes | No |
| Shiore/chew tobacco: | 162 | INO | If yes, please describe | 163 | 140 |
| there anything else about having dental treatme | nt that v | ou woul | d like us to know? | Yes | N |

| Patient Name | | | | MEDICAL HISTORY | | | | | |
|--------------|---|---------------|--|--|----|-----------------------------------|-------|-----|--|
| itient | Account No. | Medical Alert | | | | | | | |
| 1. | Have you been under the care of a medical do | | | | | | Yes | N | |
| | If yes, for what?Physician's Name | | | DL | | | - | | |
| | | | | | | | | | |
| 2 | AddressHave you taken any medication or drugs durin | | | | | | | N | |
| 2. | Are you taking any medication, drugs or pills n | - | and the same of the same of | | | | | 1 | |
| ٥. | If yes, please list name and dosage | lOW f | *********** | | | | tes | 1) | |
| 1 | Have you ever taken prescription medications | for wein | ht loss (diet r | | | | - Vas | N | |
| 7. | If yes, did you take any of the following: | Yes | No | Fen-Phen (Fenflurami | | | 165 | | |
| | in yes, and you take any or the lonowing. | Yes | No | Pondimen (Fenflurami | | perminer | | | |
| | | Yes | No | Redux (Dexfenfluramin | | | | | |
| | If yes to any of the above, did you have a med | | | THE PROPERTY OF THE PARTY OF TH | | | Vas | 1 | |
| 5 | Are you aware of having an allergic (or advers | | | | | | | i | |
| Ų. | If yes, please list: | , rous | don to dry m | saloution of outstance, | | | 103 | | |
| 6 | Have you been a patient in the hospital during | the pas | t five years? | | | | Yes | 1 | |
| 7. | | | | | | | | | |
| | Heart (Surgery, Disease, Attack) Yes No | | | Yes | No | Hepatitis A (infectious) B (serum | Yes I | | |
| | Chest Pain | | | Yes | No | Venereal Disease | | | |
| | Congenital Heart Disease Yes No | | | s Yes | No | A.I.D.S. | | | |
| | Heart Murmur Yes No | | · \ | Yes | No | H.I.V. Positive | | | |
| | High Blood Pressure Yes No | | | Yes | No | Cold Sores/Fever Blisters | | | |
| | Mitral Valve Prolapse Yes No | | | Yes | No | Blood Transfusion | Yes | 3 | |
| | Artificial Heart Valve | | | Yes | No | Hemophilia | Yes | 3 1 | |
| | Heart Pacemaker | | | Yes | No | Sickle Cell Disease | Yes | 3 | |
| | Rheumatic Fever Yes No | As | thma | Yes | No | Bruise Easily | Yes | 3 | |
| | Arthritis/Rheumatism | На | y Fever | Yes | No | Liver Disease | Yes | ; | |
| | Cortisone Medicine | | A COLUMN TO THE REAL PROPERTY OF THE PARTY O | Yes | No | Yellow Jaundice | | | |
| | Swollen Ankles Yes No | All | ergies or Hive | s Yes | No | Neurological Disorders | Yes | 3 | |
| | Stroke Yes No | Sir | nus Trouble | Yes | No | Epilepsy or Seizures | Yes | 3 | |
| | Diet (Special/Restricted) Yes No | | division of the second | by Yes | No | Fainting or Dizzy Spells | | | |
| | Artificial Joints (hip, knee, etc.) Yes No | | 1.7 | Yes | No | Nervous/Anxious | | | |
| | Kidney Trouble Yes No | | | Yes | No | Psychiatric/Psychological Care. | - | | |
| 8. | Do you use more than two pillows to sleep? | | | | | | | 1 | |
| 9. | Have you lost or gained more than 10 pounds | | The second second second second | | | | | | |
| | Do you have or have you had any disease, co | ndition, | or problem no | ot listed? | | | Yes | 1 | |

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. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may realease 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_