atient Name					MEDICAL HISTORY					
atient	Account No.			N	Medical Alert					
1.	Physician's Name Have you had any medical care w			•					No	
2.	Describe Have you taken any medication o	or drug:	s during					Yes	No	
	If yes, please list name and dosage	_								
3.	Are you currently taking any medi		, drugs,	pills or herbal remedi	ies, including regular of	dosages	of aspirin?	Yes	No	
4	If yes, please list name and dosage Have you ever taken bone loss programme to the second sec	_	on drug	e such as Fosamay A	Actonel Boniva or oth	er hisnha	nenhonates?	Vas	No	
٦.	If yes, please list name and dosage		_					163	NO	
5.	Are you aware of having an allerg							Yes	No	
	If yes, please specify									
6.	Have you been a patient in the ho	•	-					Yes	No	
7.	Indicate which of the following yo	ou have	had, o	r have at present. Cir	cle "yes" or "no" to e	ach item.				
	Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle)	Yes	No	
	Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease		No	
	Congenital Heart Disease		No	Thyroid Problems	Yes	No	A.I.D.S./H.I.V. Positive	Yes	No	
	Heart Murmur		No	Glaucoma		No	Cold Sores/Fever Blisters		No	
	High/Low Blood Pressure		No		Yes	No	Blood Transfusion		No	
	Mitral Valve Prolapse		No		Yes	No	Hemophilia		No	
	Artificial Heart Valve/Pacemaker Rheumatic Fever	Yes Yes	No No	Tuberculosis	Yes Yes	No No	Sickle Cell Disease Bruise Easily		No No	
	Arthritis/Rheumatism	Yes	No	Asthma		No	Liver Disease/Yellow Jaundice .		No	
	Cortisone Medicine	Yes	No	Hay Fever/Allergy/h		No	Neurological Disorders		No	
	Swollen Ankles		No	Latex Sensitivity		No	Epilepsy or Seizures		No	
	Stroke	Yes	No	Sinus Trouble		No	Fainting or Dizzy Spells		No	
	Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No	
	Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care.	Yes	No	
	Kidney Trouble	Yes	No	Tumors	Yes	No	Cancer	Yes	No	
8.	Have you lost or gained more tha	ın 10 p	ounds ir	n the past year?				Yes	No	
	Do you have or have you had any								No	
•	If yes, please list:	,	•	, I					-	
10.	Women: Are you pregnant or t	hink yo	u could	be pregnant? Yes	sMonths	No	Nursing? Yes No)		
	Do you use birth control prescrip								No	
	understand the above infor	rmatic	n ie n	ecessary to provi	de me with denta	l cara i	n a safe and efficient mann	or I h	3VA	
	answered all questions to th			• •						
ä	ask the respective health ca	re pro	vider	or agency, who n						
6	any change in my health or i	medic	ation.							
_	151'						Data			
۲	atient/Guardian Signature						Date			
H	listory Review									
_							5.			
	Pentist Signature						Date			

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Patient Name	DENTAL HISTORY
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.

		Last Full Mouth X-rays			
What was done at your last dental visit?					
Previous Dentist's Name			Telephone		
Address			State Zip		
How often do you have dental examinations?					
How often do you brush your teeth?					
Have you ever used or are currently using topical fluoride? Yes N	lo				
What other dental aids do you use? (Interplak, toothpick, etc.)					
Do you have any dental problems now? Yes No If yes, ple	ease describ	oe:			
Are any of your teeth sensitive to:			Have you ever had:		
Hot or cold?	Yes	No	Orthodontic treatment?	Yes	No
Sweets?		No	Oral Surgery?		No
Biting or Chewing?		No	Periodontal treatment?		No
Have you noticed any mouth odors or bad tastes?		No	Your teeth ground or the bite adjusted?		No
Do you frequently get cold sores, blisters or any other oral lesions?		No	A bite plate or mouth guard?		No
			A serious injury to the mouth or head?		No
Do your gums bleed or hurt?	Yes	No	Please describe, including cause		
Have your parents experienced gum disease or tooth loss?	Yes	No			
Have you noticed any loose teeth or change in your bite?	Yes	No	Have you experienced:		
Does food tend to become caught in between your teeth?	Yes	No	Clicking or popping of the jaw?	Yes	No
If yes, where			Pain? (joint, ear, side of face)	Yes	No
			Difficulty in opening or closing the mouth?	Yes	No
Do you:			Difficulty in chewing on either side of the mouth?		No
Clench or grind your teeth while awake or asleep?		No	Headaches, neckaches or shoulder aches?		No
Bite your lips or cheeks regularly?		No	Sore muscles (neck, shoulders)?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, etc.)		No			
Mouth breathe while awake or asleep?		No	Are you satisfied with your teeth's appearance?		No
Have tired jaws, especially in the morning?		No	Would you like to replace your silver fillings?		No
Snore or have any other sleeping disorders?		No	Would you like to keep all of your teeth all of your life?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No			
Do you feel nervous about having dental treatment?				Yes	No
Please describe					
Have you ever had an upsetting dental experience?				Yes	No
Please describe					
Have you ever been told to take a pre-medication prior to dental treat	tment?			. Yes	No
Is there anything else about having dental treatment that you wo	uld lika us	to know?		Vac	No

(Please complete other side)