

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING:

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. hospitalization for illness or injury | <input type="checkbox"/> | <input type="checkbox"/> | 26. arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. allergic reaction to | | | 27. glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen | | | 28. contact lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin | | | 29. head or neck injuries | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin | | | 30. epilepsy, convulsions (seizures) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline | | | 31. viral infections and cold sores | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> codeine | | | 32. any lumps or swelling in the mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic | | | 33. hives, skin rash, hay fever..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride | | | 34. venereal disease | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (gold, stainless steel) | | | 35. hepatitis (type _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex | | | 36. HIV / AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> any other medications _____ | | | 37. tumor, abnormal growth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems..... | <input type="checkbox"/> | <input type="checkbox"/> | 38. radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | 39. chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | 40. emotional problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. scarlet fever | <input type="checkbox"/> | <input type="checkbox"/> | 41. psychiatric treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. high blood pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | 42. antidepressant medication..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 43. alcohol / drug dependency | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. a stroke | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 10. artificial prosthesis (i.e. heart valve or joints) | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| 11. anemia or other blood disorder)..... | <input type="checkbox"/> | <input type="checkbox"/> | 44. presently being treated for any illness..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. prolonged bleeding due to a slight cut..... | <input type="checkbox"/> | <input type="checkbox"/> | 45. aware of a change in your general health .. | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. emphysema | <input type="checkbox"/> | <input type="checkbox"/> | 46. often exhausted or fatigued..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | 47. subject to frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma..... | <input type="checkbox"/> | <input type="checkbox"/> | 48. a heavy smoker (1 pack or more a day) | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. sinus problems | <input type="checkbox"/> | <input type="checkbox"/> | 49. considered a touchy person | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease..... | <input type="checkbox"/> | <input type="checkbox"/> | 50. often unhappy or depressed | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease..... | <input type="checkbox"/> | <input type="checkbox"/> | 51. easily upset or irritated | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice | <input type="checkbox"/> | <input type="checkbox"/> | 52. FEMALE - taking birth control pills | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid or parathyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | 53. FEMALE - pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency | <input type="checkbox"/> | <input type="checkbox"/> | 54. MALE - prostate disorders..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 23. diabetes | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 24. stomach or duodenal ulcer | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 25. digestive disorders..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment _____

List any medications, herbal supplements, and or vitamins taken within the last two years _____

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY
OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature _____ Date _____

Doctor's Remarks: _____

Doctor's Signature _____

DENTAL HISTORY

Referred by _____

Previous Dentist _____ How long _____

Most recent dental exam _____ Most recent detail x-ray _____

Most recent dental treatment _____

How often do you have your teeth cleaned? 3 mo. _____ 4 mo. _____ 6 mo. _____ 1 yr. or longer _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

- 1. unhappy with the appearance of your teeth YES NO
- 2. unfavorable dental experiences YES NO
- 3. dental fears YES NO
- 4. problems with effectiveness or bad reactions to dental anesthetic YES NO
- 5. past orthodontic treatment (braces) when? YES NO
- 6. past periodontal (gum) treatment when? YES NO
- 7. bleeding gums YES NO
- 8. avoid brushing any part of your mouth YES NO
- 9. part of of your mouth is sensitive to temperature YES NO
- 10. sore teeth YES NO
- 11. a burning sensation in your mouth YES NO
- 12. difficulty swallowing YES NO
- 13. an unpleasant taste or odor in your mouth YES NO
- 14. dry mouth, throat, and/or eyes YES NO
- 15. jaw problems (temporomandibular joint) YES NO
- 16. difficulty opening your mouth widely YES NO
- 17. stiff neck muscles or sore facial muscles YES NO
- 18. awoken with an awareness of your teeth or jaws YES NO
- 19. tension headaches YES NO
- 20. clench or grind your teeth YES NO
- 21. jaw clicking or popping YES NO
- 22. lost any teeth YES NO
- 23. do you sweat or tremble a lot during examinations YES NO
- 24. do strange people or places make you afraid YES NO

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a partial or complete artificial denture, please complete the following:

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | (Please check Yes or No) |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your present denture been relined? When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your present denture a problem? Describe _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the appearance? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the comfort? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the chewing ability? _____ |
- When did you receive your first partial or complete denture? _____
- How long have you worn your present denture? _____

Patient's Signature _____ Date _____

Doctor's Remarks: _____
_____ Doctor's Signature _____