Dental Medical History

1. Purpose of visit: ________________________________

2. How long has it been since your last dental treatment: ________________________________

3. Are any of your teeth sensitive to: hot, cold, sweets, pressure? If so, which teeth? ________________

4. Are you experiencing any pain or discomfort at this time? YES NO

5. Have you ever had gum treatment or gum surgery? YES NO

6. Do your gums bleed or hurt? YES NO

7. Do you have any sores or lumps in or near your mouth? YES NO

8. Does your jaw pop or click? YES NO

9. Do you often have headaches, neck aches or shoulder aches? YES NO

   What time of day? Morning / Night

10. Have you experienced pain or difficulty when chewing? YES NO

11. Have you experienced difficulty in opening and closing? YES NO

12. Do you clench or grind your teeth (while awake or asleep)? YES NO

13. Are you happy with the appearance of your teeth? YES NO

14. Have you ever had any problems or complications with previous dental treatment? YES NO

15. How often do you brush your teeth? ________________________________________________

16. How often do you floss your teeth? ________________________________________________

17. Physician's (or medical clinic's) name? ______________________________________________

18. When was your last physical exam? ________________________________________________

19. Are you under the care of a physician? YES NO

   Since when? ________________ Why? ________________________________________________

20. Has there been any change in your general health within the past year? YES NO

21. Have you ever had a serious illness or major surgery? YES NO

   If so, explain ________________________________________________

22. Are you allergic to any medications or substances? YES NO

   If so, explain ________________________________________________

23. Do you have other allergies? YES NO

24. Have you ever had any problems with (or adverse reactions to) penicillin or other antibiotics, sulfa drugs, anesthetics, or other medications? YES NO

25. Are you sensitive to any metals or latex? YES NO

26. Are you taking medications? (Include antibiotics) YES NO

   Please list ________________________________________________

27. Are you taking any over the counter medications and/or supplements?

   Please list ________________________________________________

28. Have you ever taken any prescription weight loss medications? YES NO

29. Are you taking any bisphosphonate medications (i.e. Fosamax, Boniva)? YES NO

30. Are you being or have you been treated for chemical dependency? YES NO

31. Do you smoke, chew, use snuff or any other forms of tobacco? YES NO

32. Are you pregnant or do you suspect you may be? YES NO

   How many weeks, due date ________________
33. Have you had or do you test positive for hepatitis? .................................................. YES NO
34. Have you tested H.I.V. positive? ................................................................. YES NO
35. Have you ever been treated or been told that you might have
a heart condition, heart disease or a heart murmur? ........................................... YES NO
36. Do you have a pacemaker, artificial heart valve implant, artificial joints,implants, or prosthesis? ................................................................. YES NO
37. Do you have or have you ever had any of the following diseases, or conditions?
   If you answer yes, please indicate when.
   a. prolapsed mitral valve? .................................................. YES NO
   b. high or low blood pressure? .................................................. YES NO
   c. stroke? .................................................. YES NO
   d. asthma or sinus trouble? .................................................. YES NO
   e. tuberculosis (T.B.)? .................................................. YES NO
   f. epilepsy or seizure disorder? .................................................. YES NO
   g. diabetes? .................................................. YES NO
   h. thyroid problems? .................................................. YES NO
   i. stomach ulcers? .................................................. YES NO
   j. eating disorders? .................................................. YES NO
   k. kidney trouble, transplant or dialysis? .................................................. YES NO
   l. liver disease or jaundice? .................................................. YES NO
   m. rheumatic fever, scarlet fever, or rheumatic heart disease? .................................. YES NO
   n. inflammatory diseases (arthritis, rheumatism)? .................................. YES NO
   o. any sexually transmitted disease? .................................................. YES NO
   p. If you are 26 years old or younger have you completed the HPV series? .................................. YES NO
   q. bled excessively after being cut or injured? .................................. YES NO
   r. any blood disorders (anemia, leukemia, etc.)? .................................. YES NO

38. Is there anything else we should know about your health
   that we have not covered in this form? .................................................. YES NO

   ________________________________________________________________
   ________________________________________________________________

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient’s Signature ________________________________________________ Date: ____________

Provider’s Signature ________________________________________________ Date: ____________