Dental & Medical History

Dental History

Patient Name:_____

Former Dentist:_____

Date of last dental Visit_____Date of last x-rays:_____How often do you brush?_____Floss_____

Please check all that apply

[ ]Bad Breath
[ ]Bleeding gums
[ ]Blisters on lips and mouth
[ ]Burning sensation on tongue
[ ]Chew on one side of the mouth
[ ]Cigarette/Pipe/Cigar Smoking
[ ]Clicking or popping jaw
[ ]Dry mouth
[ ]Fingernail Biting:
[ ] Mouth breathing
[ ]Food collection between teeth
[ ] Foreign objects
[ ] Grinding teeth
[ ] Gums swollen or tender
[ ] Jaw pain
[ ] Jaw tiredness
[ ] Lip or cheek biting
[ ] Loose teeth/Broken fillings
[ ]Mouth pain, brushing
[ ] Orthodontic treatment
[ ] Pain around ear
[ ] Periodontal treatment
[ ] Sensitivity to cold
[ ] Sensitivity to heat
[ ] Sensitivity to sweets
[ ] Sensitivity to biting
[ ] Sores/growths in mouth

Medical History

Physician's Name:_____Date of last Visit:_____

Have you ever taken any medications containing bisphosphonates?`This includes brands such as Fosomax, Actonel, dibronel, Boniva,Aredia, and Zometes. [ ]Yes [ ] No

Please check all that apply

[ ]AIDS/HIV
[ ]Anemia
[ ] Arthritis, Rheumatism
[ ] Artificial Joins
[ ] Asthma, Use Inhaler [ ]Yes [ ]No
[ ]Back problems
[ ]Bleeding abnormally,with extractions or surgery
[ ]Blood Disease
[ ]Cancer,Type_____
[ ] Chemical Dependency
[ ]Chemotherapy, When_____
[ ]Circulatory, problems
[ ] Congenital Heart Lesions
[ ] Cortisone Treatment
[ ] Cough, persistent/bloody
[ ] Diabetes
[ ]Dizziness
[ ] Emphysema
[ ] Epilepsy
[ ] Fainting
[ ] Glaucoma
[ ] Headaches
[ ] Heart Murmur
[ ] Heart Problems
[ ] Hepatitis, Type_____
[ ] Herpes
[ ]High Blood Pressure
[ ] Jaundice
[ ] Jaw pain
[ ] Kidney Disease
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Nervous Problems
[ ] Pace Maker
[ ] Psychiatric Care
[ ] Weigh Loss/Gain
[ ] Sleep Apnea
[ ] Snoring
[ ] Scarlet Fever
[ ] Shortness of breath
[ ] Sinus Trouble
[ ] Skin Rash
[ ] Special Diet
[ ] Stroke
[ ] Swollen feet/Ankles
[ ] Swollen Neck Glands
[ ] Thyroid Problems
[ ] Tonsillitis
[ ] Tuberculosis
[ ]Tumor or growth on head or neck
[ ] Ulcer
[ ] Venereal Disease
[ ] Respiratory Disease

Do you wear contact lenses?[ ]Yes [ ]No
Are you pregnant? [ ]Yes [ ]No Due Date:_____
Do you sleep well at night?[ ]Yes [ ]No

Are you taking birth control pills? [ ]Yes [ ]No
Are you Nursing? [ ]Yes [ ]No
Do you snore during sleep? [ ]Yes [ ]No

Medications

List any medications you are currently taking and correlating diagnosis:_____

_____

_____

Allergies

[ ]Aspirin
[ ] Codeine
[ ] Dental Anesthetics
[ ] Erythromycin
[ ]Latex
[ ] Metals
[ ] Penicillin
[ ] Sulfa
[ ] Tetracycline
[ ] Other_____
_____

Signature:_____Date:_____Reviewed by:_____
(If minor, parent signature required)

Medical History Update

Signature:_____Appointment Date:_____