



# DENTAL AND MEDICAL HISTORY

## DENTAL HISTORY

Reason for today's visit: \_\_\_\_\_ Former dentist: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

How would you rate the condition of your mouth?  Excellent  Good  Fair  Poor

I routinely see my dentist every:  3 MOS  4 MOS  6 MOS  12 MOS  Not routinely

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

### PLEASE CIRCLE YES IF YOU HAD ANY OF THE FOLLOWING:

- |       |                                |       |                                   |       |                       |
|-------|--------------------------------|-------|-----------------------------------|-------|-----------------------|
| Y / N | Bad Breath                     | Y / N | Fingernail Biting                 | Y / N | Orthodontic Treatment |
| Y / N | Bleeding Gums                  | Y / N | Food Collection Between The Teeth | Y / N | Pain Around Ear       |
| Y / N | Blisters On Lips Or Mouth      | Y / N | Grinding Teeth                    | Y / N | Periodontal Treatment |
| Y / N | Coffee, Tea                    | Y / N | Jaw Pain Or Tiredness             | Y / N | Sensitivity To Biting |
| Y / N | Burning Sensation On Tongue    | Y / N | Lip Or Cheek Biting               | Y / N | Sensitivity To Cold   |
| Y / N | Do You Smoke?                  | Y / N | Loose Teeth Or Broken Filling     | Y / N | Sensitivity To Heat   |
| Y / N | Clicking Or Popping Jaw        | Y / N | Mouth Breathing                   | Y / N | Sensitivity To Sweets |
| Y / N | Dry Mouth                      | Y / N | Mouth Pain, Brushing              | Y / N | Swollen Or Tender     |
| Y / N | Sores Or Growths In Your Mouth |       |                                   |       |                       |

## MEDICAL HISTORY

Physician's name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen" ?  YES  NO

These include tiludronate (Skelid), alendronate(Fosamax), risedronate(Actonel), etidronate(Didronel), ibandronate (Bonival), pamidronate (Aredia) and zoledronic acid (Zometa).

Have you ever had any serious illnesses or operations?  NO  YES, Please describe \_\_\_\_\_

**WOMEN:** Are you pregnant?  YES  NO Nursing?  YES  NO Taking birth control?  YES  NO

### PLEASE CIRCLE YES IF YOU HAD ANY OF THE FOLLOWING:

- |       |                         |       |                       |       |                     |       |                      |
|-------|-------------------------|-------|-----------------------|-------|---------------------|-------|----------------------|
| Y / N | Anemia                  | Y / N | Diabetes              | Y / N | Hepatitis           | Y / N | Scarlet Fever        |
| Y / N | Arthritis               | Y / N | Cortisone Treatments  | Y / N | Hernia Repair       | Y / N | Shortness Of Breath  |
| Y / N | Artificial Heart Valves | Y / N | Cough, Persistent     | Y / N | High Blood Pressure | Y / N | Skin Rash            |
| Y / N | Artificial Joints, Pins | Y / N | Cough Up Blood        | Y / N | HIV/AIDS            | Y / N | Spleen Removed       |
| Y / N | Asthma                  | Y / N | Congenital Heart      | Y / N | Jaw Pain            | Y / N | Stroke               |
| Y / N | Back Problems           | Y / N | Epilepsy              | Y / N | Kidney Disease      | Y / N | Swelling Feet/Ankles |
| Y / N | Bleeding Abnormally     | Y / N | Fainting Or Dizziness | Y / N | Liver Disease       | Y / N | Thyroid Problems     |
| Y / N | Blood Disease           | Y / N | Headaches             | Y / N | Pacemaker           | Y / N | Tobacco Habit        |
| Y / N | Chemical Dependency     | Y / N | Heart Murmur          | Y / N | Radiation Treatment | Y / N | Tuberculosis         |
| Y / N | Chemotherapy            | Y / N | Heart Problems        | Y / N | Respiratory Disease | Y / N | Ulcer                |
| Y / N | Circulatory Problems    | Y / N | Hemophilia            | Y / N | Rheumatic Fever     | Y / N | Venereal Disease     |

List all medications you are taking: \_\_\_\_\_

### PLEASE CIRCLE IF YOU ARE ALLERGIC TO:

- Aspirin  Codeine  Latex  Local Anesthesia  
 Penicillin  Other \_\_\_\_\_

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor of any changes in my medical history or any new medications I may be taking.

X  
\_\_\_\_\_  
Patient Signature Or Legal Guardian / Representative Signature

\_\_\_\_\_  
Date

X  
\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date