

# 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 \_\_\_\_\_

<b>HAVE YOU EVER HAD THE FOLLOWING:</b>		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, acetomenophen			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"/>	<b>ARE YOU:</b>		
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 dental x-ray \_\_\_\_\_

Most recent dental treatment \_\_\_\_\_

How often do you have your teeth cleaned?    3 mo. \_\_\_\_\_    4 mo. \_\_\_\_\_    6 mo. \_\_\_\_\_    1 year 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 .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. unfavorable dental experiences .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. dental fears .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. problems with effectiveness or bad reactions to dental anesthetic ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. orthodontic treatment (braces) when .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. periodontal (gum) treatment when .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. bleeding gums .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. avoid brushing any part of your mouth .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. part of your mouth is sensitive to temperature .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. sore teeth .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. a burning sensation in your mouth .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. difficulty swallowing .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. an unpleasant taste or odor in your mouth .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. dry mouth, throat, and or eyes .....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. jaw problems (temporomandibular joint) .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. difficulty opening your mouth widely .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. stiff neck muscles .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. awaken with an awareness of your teeth or jaws .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. tension headaches .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. clench or grind your teeth .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. jaw clicking or popping .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. lost any teeth .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. do you sweat or tremble a lot during examination .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. do strange people or places make you afraid .....                      | <input type="checkbox"/> | <input type="checkbox"/> |

**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 \_\_\_\_\_