

Medical / Dental History

PATIENT NAME \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Do you take, or have you taken, Phen-Fen or Redux?
Are you on a special diet?
Do you use or have you used tobacco products?
Have you stopped the use of tobacco products?
Does your family have a history of oral cancer?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics NSAIDs Other

Do you have, or have you had, any of the following?

Table with 4 columns of medical conditions and Yes/No options. Includes conditions like AIDS, Diabetes, Hypertension, etc.

Have you ever had any serious illness not listed above? If yes, please explain:

Are you under a physician's care now? If yes please list Dr's name and #

Are you taking any prescription medications, herbal supplements, or over the counter drugs? If yes, please list all prescription, herbal, and over the counter medications taken:

Blank lines for listing medications and other details.

Is there any additional information that we should be aware of regarding your medical history?

Blank line for additional information.

**Medical / Dental History**

**Do you have any of the following problems:**

- ◆Sensitivity (hot, cold, sweet)  Yes  No
- ◆Tooth pain or discomfort when chewing  Yes  No
- ◆Headaches, earaches, neck pain  Yes  No
- ◆Jaw joint pain  Yes  No
- ◆Teeth or fillings breaking  Yes  No
- ◆Grinding or clenching teeth  Yes  No
- ◆Bleeding, swollen or irritated gums  Yes  No
- ◆Loose, tipped or shifting teeth  Yes  No
- ◆Bad breath or bad taste in your mouth  Yes  No

**Do you have or have you had any of the following?**

- ◆Dentures  Yes  No
- ◆Partial dentures  Yes  No
- ◆Braces  Yes  No
- ◆Periodontal (gum) treatments  Yes  No

**Please share the following dates:**

- ◆Your last cleaning  /
- ◆Your last oral cancer screening  /
- ◆Your last complete X-Rays  /

**What is the most important thing that you would like us to address, at today’s dental visit?**

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**If I could change my smile, I would:**

- ◆Make my teeth brighter
- ◆Make my teeth straighter
- ◆Close spaces
- ◆Replace black metal fillings with natural, tooth- colored fillings
- ◆Repair chipped teeth
- ◆Replace missing teeth
- ◆Replace old crowns that don’t match
- ◆ Show less gum tissue when smiling
- ◆Have a smile makeover

**On a scale of 1 – 10, with 10 being the highest rating:**

- ◆How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10
- ◆Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

**What are your most important future goals for your smile and dental health?**

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To the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient’s) health. It is my responsibility to inform the dental office of any changes in medical status.

**SIGNATURE OF PATIENT, PARENT, or GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_