



# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Age \_\_\_\_\_

Name of Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health?  Poor  Fair  Good

HAVE YOU EVER HAD THE FOLLOWING: YES NO

1. hospitalization for illness or injury .....  YES  NO
2. allergic reaction to  
 aspirin, ibuprofen, acetomenophen  
 penicillin  
 erythromycin  
 tetracycline  
 codeine  
 local anesthetic  
 fluoride  
 metals (gold, stainless steel)  
 latex  
 other medications \_\_\_\_\_
3. heart problems .....  YES  NO
4. heart murmur .....  YES  NO
5. rheumatic fever .....  YES  NO
6. scarlet fever .....  YES  NO
7. high blood pressure .....  YES  NO
8. low blood pressure .....  YES  NO
9. a stroke .....  YES  NO
10. artificial prosthesis (heart valve or joint) .....  YES  NO
11. anemia or other blood disorder .....  YES  NO
12. prolonged bleeding due to a slight cut .....  YES  NO
13. emphysema .....  YES  NO
14. tuberculosis .....  YES  NO
15. asthma .....  YES  NO
16. sinus problems .....  YES  NO
17. kidney disease .....  YES  NO
18. liver disease .....  YES  NO
19. jaundice .....  YES  NO
20. thyroid or parathyroid disease .....  YES  NO
21. hormone deficiency .....  YES  NO
22. high cholesterol .....  YES  NO
23. diabetes .....  YES  NO

24. stomach or duodenal ulcer .....  YES  NO
25. digestive disorders .....  YES  NO
26. arthritis .....  YES  NO
27. glaucoma .....  YES  NO
28. contact lenses .....  YES  NO
29. head or neck injuries .....  YES  NO
30. epilepsy, convulsions (seizures) .....  YES  NO
31. viral infections and cold sore .....  YES  NO
32. any lumps or swelling in the mouth .....  YES  NO
33. hives, skin rash, hay fever .....  YES  NO
34. venereal disease .....  YES  NO
35. hepatitis (type \_\_\_\_\_) .....  YES  NO
36. HIV / AIDS .....  YES  NO
37. tumor, abnormal growth .....  YES  NO
38. radiation therapy .....  YES  NO
39. chemotherapy .....  YES  NO
40. emotional problems .....  YES  NO
41. psychiatric treatment .....  YES  NO
42. antidepressant medication .....  YES  NO
43. alcohol / drug dependency .....  YES  NO

ARE YOU:

44. presently being treated for any illness .....  YES  NO
45. aware of change in your general health .....  YES  NO
46. often exhausted or fatigued .....  YES  NO
47. subject to frequent headaches .....  YES  NO
48. a smoker (cigarettes/day \_\_\_\_\_) .....  YES  NO
49. considered a touchy person .....  YES  NO
50. often unhappy or depressed .....  YES  NO
51. easily upset or irritated .....  YES  NO
52. FEMALE: - taking birth control pills .....  YES  NO
53. FEMALE: - pregnant .....  YES  NO
54. MALE: - prostate disorders .....  YES  NO

Please describe any current medical treatment, impending surgery or other treatment that may affect your dental treatment.

List any medication, 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?  3mo.  4mo.  6mo.  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. awoken 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)

Has your present denture been relined? When \_\_\_\_\_

Is your present denture a problem? Describe \_\_\_\_\_

Satisfied with the appearance? \_\_\_\_\_

Satisfied with the comfort? \_\_\_\_\_

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 \_\_\_\_\_