Dental and Medical Patient Information

To provide you with the best possible care, it is important that you inform about your health. Please complete this medical history form. This information is confidential. If you are completing this for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Physicians Name _____ Date of Last Visit to Medical Doctor _____

Previous Dentist _____ Date of Last Visit to Dentist _____

Emergency Contact _____ Phone Number _____

How did you hear about us?
_____

Are you nervous about dental treatment? YES NO

Have you had problems with pervious dental treatment? YES NO

Do you gag easily? YES NO

Do you have any dental implants, dentures, or partials? YES NO

Does food catch between your teeth? YES NO

Do you have difficulty chewing your food? YES NO

Do you chew on only one side of your mouth? YES NO

Do you avoid brushing any part of your mouth because of pain? YES NO

Do your gums bleed easy? YES NO

Do your gums bleed when you floss? YES NO

Do your gums feel swollen or tender? YES NO

How you ever noticed slow-healing sores in or around your mouth? YES NO

Are your teeth sensitive? YES NO

Do you feel twinges of pain when your teeth come in contact with **HOT** food or liquids? YES NO

Do you feel twinges of pain when your teeth come in contact with **COLD** food or liquids? YES NO

Do you feel twinges of pain when you teeth come in contact with sours? YES NO

Do you feel twinges of pain when your teeth come in contact with sweets? YES NO

Do you take fluoride supplements? YES NO

Are you dissatisfied with the appearance of your teeth? YES NO

Do you want to keep your teeth? YES NO

Do you want complete dental care? YES NO

How often do you brush? _____ How often do you floss? _____

Does your jaw make noise so that it bothers you or others? YES NO

Do you clench or grind your jaws frequently? YES NO

Do your jaws ever feel tired? YES NO

Does your jaw get stuck so that you can't open freely? YES NO

Does it hurt when you chew or open wide to take a bite? YES NO

Do you have earaches or pain in front of the ears? YES NO

Do you have any jaw symptoms or headaches after waking up in the morning? YES NO

Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? YES NO

Do you find jaw pain or discomfort extremely frustrating or depressing? YES NO

Do you take medications for pain or discomfort? (pain relievers, muscle relaxants, antidepressants) YES NO

Do you have a temporomandibular (jaw) disorder (TMD)? YES NO

Do you have pain in the face, cheeks, jaws, joints, throat or temples? YES NO

Are you unable to open your mouth as far as you want? YES NO

Are you aware of an uncomfortable bite? YES NO

Have you had a blow to the jaw (trauma)? YES NO

Are you a habitual gum chewer or pipe smoker? YES NO

Medical History

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

Heart Problems YES NO If Yes, _____

Blood Problems YES NO If Yes,
_____

Allergy Problems YES NO If Yes,
_____

Intestinal Problems YES NO If Yes,
_____

Bone or Joint Problems YES NO If Yes,
_____

Diabetes YES NO If Yes,
_____

Fainting spells, Seizures, Epilepsy YES NO If Yes,
_____

Stroke(s) YES NO If Yes,
_____

Frequent or Severe Headaches YES NO If Yes,
_____

Thyroid Problems YES NO If Yes,
_____

Persistent Cough or Swollen Glands YES NO If Yes,
_____

Premedication's Required By Physician For Dental Treatment YES NO If Yes,
_____

Cancer/Tumor YES NO If Yes,
_____

Tuberculosis or Other Respiratory Disease YES NO If Yes,
_____

Do you drink alcohol - if so how much? YES NO If Yes,
_____

Do you smoke - If so how much? YES NO If Yes,
_____

Hepatitis, Jaundice, or liver Trouble YES NO If Yes,
_____

Herpes or Other STD YES NO If Yes,
_____

HIV – Positive/AIDS YES NO If Yes,
_____

Glaucoma YES NO If Yes,
_____

Do you wear contact lenses? YES NO If Yes,
_____

History of head injury YES NO If Yes,
_____

The Dental Practice
Dental & Medical Patient Information Continued

Epilepsy or other neurological disease YES NO If Yes,
_____

History of drug or alcohol abuse YES NO If Yes,
_____

Allergies

Please list all allergies
_____
_____
_____
_____

Medications

Please list all medications that you are currently taking
_____
_____
_____
_____

Additional Medication Notes That You Feel We Should Know About (Herbal Supplements)
_____
_____
_____
_____

Do you have any disease, condition or problem not listed previously that you feel we should know about? If yes, Please describe
_____
_____
_____
_____

For Women ONLY

Are you taking contraceptives or other hormones? YES NO If Yes,
_____

Are you pregnant? YES NO If Yes, Due Date
_____

Are You Nursing YES NO

Have you reached menopause YES NO

_____
_____

Patient Signature Date
If Patient Is Under 18, Parent or Legal Guardian Signature