

PATIENT NAME _____ BIRTH DATE _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Heart Pacemaker
- Congenital Heart Problems
- Artificial heart valve
- Artificial joint
- Rheumatic fever or rheumatic heart disease
- High blood pressure
- Low blood pressure
- Stroke
- Lung or breathing problems
- Hepatitis/Jaundice/or other liver disease
- Blood transfusion
- Diabetes (insulin/diet controlled)
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hay fever or sinus trouble
- Allergies or hives
- Asthma
- Multiple Sclerosis
- Neuro-muscular disease
- Kidney disease
- Thyroid or parathyroid problems
- Ulcers
- Digestive disorders/ acid reflux
- Arthritis/Rheumatism
- Glaucoma
- Head or neck injuries
- Sexually transmitted disease
- Chemotherapy
- Radiation therapy
- Emotional problems
- Psychiatric treatment
- Alcohol/drug dependency
- Sleep Apnea
- Osteoporosis or bone disorders
- Hearing problems

Do you smoke or use chewing tobacco? Yes No

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Tetracycline
- Aspirin or Ibuprofen
- Nut Allergy
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Please list all other Medications: _____

Women:

- May be pregnant
Expected delivery date: _____
- Taking hormones or contraceptives

Name of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____

Have you been hospitalized in the last 5 years for any reason? Please explain _____



DENTAL HISTORY

Last Dental Treatment _____ Last Dental X-rays _____
 Previous Dentist _____ How long with this dentist _____
 How often are your teeth cleaned? _____

Please answer by circling YES or NO to the following:

- YES NO Is there anything you would like to change about the look or feel of your teeth?
- YES NO Dental fears or unfavorable experiences?
- YES NO Problems with effectiveness or bad reactions to dental anesthetics?
- YES NO Orthodontic treatment? (Date _____)
- YES NO Periodontal (gum) treatment?
- YES NO Avoid brushing any part of your mouth?
- YES NO Have gums that bleed when brushing or flossing?
- YES NO Have teeth that are sensitive to hot or cold?
- YES NO Have sore or painful teeth?
- YES NO Have a burning sensation in your mouth?
- YES NO Have difficulty swallowing?
- YES NO Have an unpleasant taste or odor in your mouth?
- YES NO Dry mouth, throat, and/or eyes?
- YES NO Jaw problems (temporomandibular joint)?
- YES NO Difficulty in opening your mouth widely?
- YES NO Stiff neck muscles?
- YES NO Awaken with an awareness of your teeth or jaw?
- YES NO Have tension headaches?
- YES NO Clench or grind your teeth?
- YES NO Lost any teeth?
- YES NO Wear a bite splint, night guard, orthodontic retainer, or sleep apnea appliance?
- YES NO Sores or growths in your mouth?
- YES NO Loose teeth or broken fillings?
- YES NO Food collection between teeth?
- How often do you brush? _____
- How often do you floss? _____

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a removable partial or complete denture, please complete the following:

YES NO Has your present denture been relined? When? _____

YES NO Is your present denture a problem? Describe _____

YES NO Are you satisfied with the appearance?

YES NO Are you satisfied with the comfort?

When did you receive your first partial or complete denture? _____

How long have you worn your present denture? _____

Patient Signature (parent/guardian) _____ **Date** _____

Doctor's Signature _____ **Date** _____

Reviewed _____ Date _____

Reviewed _____ Date _____