



## Medical History

1. Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone # (    ) \_\_\_\_\_

2. What is the date of your last physical examination? \_\_\_\_\_

3. Please check any of the following conditions you have had or have at present:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Allergies _____              | <input type="checkbox"/> Cardiac Transplant                 | <input type="checkbox"/> Heart Attack               | <input type="checkbox"/> Previous Infective Endocarditic |
| <input type="checkbox"/> Anemia _____                 | <input type="checkbox"/> Congenital heart Disease excluding | <input type="checkbox"/> Heart Pacemaker            | <input type="checkbox"/> Psychiatric Care                |
| <input type="checkbox"/> Angina Pectoris              | <input type="checkbox"/> mistral valve prolapsed            | <input type="checkbox"/> Heart Surgery              | <input type="checkbox"/> Rheumatic Fever                 |
| <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Cough                              | <input type="checkbox"/> Hemophilia                 | <input type="checkbox"/> Sinus Problems                  |
| <input type="checkbox"/> Artificial Heart Valve       | <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Hepatitis A(Infectious)    | <input type="checkbox"/> Stomach Ulcers                  |
| <input type="checkbox"/> Artificial Joint Replacement | <input type="checkbox"/> Drug Addiction                     | <input type="checkbox"/> Hepatitis B(Serum)         | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Emphysema                          | <input type="checkbox"/> Immune Deficiency Syndrome | <input type="checkbox"/> Thyroid Disease (Hypo/Hyper)    |
| <input type="checkbox"/> Blood Pressure, High         | <input type="checkbox"/> Epilepsy                           | <input type="checkbox"/> Jaundice                   | <input type="checkbox"/> Tuberculosis                    |
| <input type="checkbox"/> Blood Pressure, Low          | <input type="checkbox"/> Excessive Bleeding                 | <input type="checkbox"/> Jaundice                   | <input type="checkbox"/> Venereal Disease                |
| <input type="checkbox"/> Bruise Easily                | <input type="checkbox"/> Fainting or Dizziness              | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> X-Ray or Cobalt Tx              |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Fever Blisters                     | <input type="checkbox"/> Liver Disease              |  |
| <input type="checkbox"/> Chemotherapy                 | <input type="checkbox"/> Glaucoma                           | <input type="checkbox"/> Nervousness                |  |
|   | <input type="checkbox"/> Hay Fever                          | <input type="checkbox"/> Prosthetic Cardiac Valve   |  |

4. Please check if you are allergic or have reacted adversely to any of the following medications:

- |                                  |   |  |  |
|----------------------------------|---|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin       | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Talwin NX         |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Fluoride           | <input type="checkbox"/> Penicillin    | <input type="checkbox"/> Tetracycline      |
| <input type="checkbox"/> Darvon  | <input type="checkbox"/> Local Anesthetic   | <input type="checkbox"/> Percodan      | <input type="checkbox"/> Valium            |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Nembutal / Seconal | <input type="checkbox"/> Sulfa Drugs   | <input type="checkbox"/> Other Antibiotics |

5. Are you aware or being allergic to any other medication or substance?  Yes  No

If yes, please list: \_\_\_\_\_

6. Have you been hospitalized or had a serious illness within the past five years?  Yes  No

7. Are you now under the care of a physician? .....  Yes  No

8. Are you now taking any medication, drugs or pills? .....  Yes  No

If yes, please list those drugs: \_\_\_\_\_

9. Have had any abnormal bleeding associated with previous extractions, surgery, or accident? .....  Yes  No

If yes, please explain: \_\_\_\_\_

10. Do your ankles swell? .....  Yes  No

11. Have you lost or gained more than 10 pounds in the past year? .....  Yes  No

12. Are you on a special diet? .....  Yes  No

13. Has your physician ever said you have a cancer or tumor? .....  Yes  No

14. Do you have any disease, condition, or problem not listed above that I should know about?.....  Yes  No

If yes, please explain: \_\_\_\_\_

**For Women:**

15. Are you taking birth control pills?.....  Yes  No

16. Are you pregnant? (If yes, what month are you now? \_\_\_\_\_) .....  Yes  No

**Consent:**

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) \_\_\_\_\_ and further authorize and consent that doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for my dependents and myself is mine, due and payable at the time services are rendered. I further understand that a 1 ½ % finance charge (18% annually will be added to any balance over 30 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Doctor \_\_\_\_\_

Parent of Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

# DENTAL HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

1. What is the purpose of this visit? \_\_\_\_\_

2. Are you having any discomfort at this time?..... Yes No

If yes, what is the discomfort? \_\_\_\_\_ Where? \_\_\_\_\_ How Long? \_\_\_\_\_

3. Date of last dental visit \_\_\_\_\_ For what purpose? \_\_\_\_\_

4. How often did you visit a dentist before then? \_\_\_\_\_

5. Date of last dental cleaning \_\_\_\_\_ Date of last full mouth x-ray series \_\_\_\_\_

6. Name of previous dentist \_\_\_\_\_

7. Do you have or have you had any of the following? Indicate with a check.

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Teeth sensitive to cold heat, sweets, pressure | <input type="checkbox"/> Burning of tongue                          | <input type="checkbox"/> Clenching or grinding teeth       | <input type="checkbox"/> Complications from extractions               |
| <input type="checkbox"/> Bleeding gums, how long? _____                 | <input type="checkbox"/> Frequent blisters on lips or mouth         | <input type="checkbox"/> Pain around ear                   | <input type="checkbox"/> Fixed bridge                                 |
| <input type="checkbox"/> Loose teeth                                    | <input type="checkbox"/> Strong gag reflex                          | <input type="checkbox"/> Unusual sound in ear while eating | <input type="checkbox"/> Removable partial                            |
| <input type="checkbox"/> Loose or broken fillings                       | <input type="checkbox"/> Oral habits; cheek, lip, Fingernail biting | <input type="checkbox"/> Bite adjustment treatment         | <input type="checkbox"/> Denture                                      |
| <input type="checkbox"/> Swelling or lump in mouth                      | <input type="checkbox"/> Cigarette, pipe or cigar smoking           | <input type="checkbox"/> Orthodontic treatment             | <input type="checkbox"/> Frequent consumption of sweet food or drinks |
| <input type="checkbox"/> Food impaction                                 | <input type="checkbox"/> Mouth breathing                            | <input type="checkbox"/> Root canal treatment              | <input type="checkbox"/> Training of dental disease                   |
| <input type="checkbox"/> Bad Breath                                     | <input type="checkbox"/> Chewing on only one side of mouth          | <input type="checkbox"/> Periodontal (gum) Treatment       | <input type="checkbox"/> Satisfaction with appearance of teeth        |
| <input type="checkbox"/> Unpleasant taste                               |   | <input type="checkbox"/> Missing teeth                     | <input type="checkbox"/> Teeth whitening                              |

8. Do you use the following? Indicate with a check.

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Tooth brush  | <input type="checkbox"/> Dental Floss                           | <input type="checkbox"/> Interdental stimulators | <input type="checkbox"/> Toothpaste, brand _____  |
| <input type="checkbox"/> Soft <input type="checkbox"/> Medium <input type="checkbox"/> Hard | <input type="checkbox"/> Unwaxed <input type="checkbox"/> Waxed | <input type="checkbox"/> Water jet devices       | <input type="checkbox"/> Mouthwash, brand _____   |
| Frequency of brushing _____   | Frequency of flossing _____                                     | <input type="checkbox"/> Fluoride supplements    | <input type="checkbox"/> Other hygiene aids _____ |

9. Have you experienced any serious problems with previous dental treatment? ..... Yes No

If yes, please explain \_\_\_\_\_

10. Is there any other information I should know about your dental health?..... Yes No

If yes, please explain \_\_\_\_\_

**FOR COMPLETION BY DENTIST:**

Significant findings from oral interview \_\_\_\_\_

General condition of teeth \_\_\_\_\_ Initial Teeth Shade Max: \_\_\_\_\_ Mand: \_\_\_\_\_

Occlusion Class I II III \_\_\_\_\_ Mobility \_\_\_\_\_

Crowns/Date \_\_\_\_\_ Bridges/Date \_\_\_\_\_

Partials/Date \_\_\_\_\_ Dentures/Date \_\_\_\_\_

Condition of present restorations \_\_\_\_\_

Overhangs \_\_\_\_\_ Contact Points \_\_\_\_\_

Abrasion \_\_\_\_\_ Gingival Recession \_\_\_\_\_

Gingival Color \_\_\_\_\_ Pockets \_\_\_\_\_

Gingival Inflammation: Light Moderate Severe Homecare Effectiveness: Good Fair Poor

Soft Plaque Buildup: Light Moderate Heavy Periodontal Condition: Good Fair Poor

Hard Calculus Buildup: Light Moderate Heavy Periodontal Diagnosis: Normal Gingivitis

Stains: Light Moderate Heavy Periodontitis: Early Moderate Advanced

Oral Cancer-Soft Tissue Exam Normal Abnormal \_\_\_\_\_

TMJ Exam: Normal Pain Popping Deviation Tooth Wear

X-Ray Evaluation: Abscesses \_\_\_\_\_ Impactions \_\_\_\_\_ Root Tips \_\_\_\_\_ Supernumerary \_\_\_\_\_

Blood Pressure / Date \_\_\_\_\_ Diagnostic Models / Date \_\_\_\_\_ Photographs / Date \_\_\_\_\_

**REFERRALS: ( for doctor's use)**

Orthodontist \_\_\_\_\_ Endodontist \_\_\_\_\_

Oral Surgeon: \_\_\_\_\_ Physician: \_\_\_\_\_

Periodontist: \_\_\_\_\_ Other: \_\_\_\_\_