Adult Medical and Dental History

Patient Name:_____ Date_____ Acct. # _____

Name Patient prefers to be called: _____ Date of Birth: _____ Sex: __M __F

Name, address and phone number of previous dentist: _____
_____

Have you seen a dental specialist (oral surgeon, periodontist, orthodontist, etc.) in the last 3 years? If yes, name and phone number_____	Y	N
Have you ever had a serious head or neck injury?	Y	N
If yes, please describe:_____		
Have you had your teeth X-rayed by another dental office in the last 3 years?	Y	N
Do any of your teeth hurt? If yes, please specify: _____	Y	N
Are your teeth sensitive to cold?	Y	N
Are your teeth sensitive to chewing or biting?	Y	N
Are your teeth sensitive to sweets?	Y	N
Do you have an unpleasant odor or taste in your mouth?	Y	N
Does food catch between your teeth?	Y	N
Do you bite your nails or chew on foreign objects like pencils?	Y	N
Do you clench or grind your teeth during the day or night?	Y	N
Do you have frequent headaches?	Y	N
Do you have difficulty opening your mouth widely?	Y	N
Does your jaw joint click or pop?	Y	N
Have you ever had a bite plate, splint, or guard?	Y	N
Are you a mouth breather?	Y	N
Do you suck your finger or thumb or do you have a tongue thrust habit?	Y	N
Have you had braces or other orthodontic treatment?	Y	N
Do you wear full or partial dentures? If yes, how old are they? _____	Y	N
Are you dissatisfied with the appearance of your teeth? If yes, please note what you wish you could change: ___color ___shape ___spacing ___crowding	Y	N
Do you consume soft drinks, candy or use chewing gum on a daily basis?	Y	N
Do you use tobacco: If yes, what kinds?_____	Y	N

How often do you brush your teeth? _____ toothpaste: _____
How often do you floss your teeth? _____
What other oral care aids do you use? ___interdental brushes ___stimudents/toothpicks ___waterpik
___mouthwash, if yes, please specify type/brand:_____
___other: _____

Please add anything you believe is important for the Doctor to know: _____
_____
_____

Health problems and medications could have an important interrelationship with your dental care. Please answer all of the following questions:

Do you have, or have you ever had, or been treated for any of the following:

(Starred items may require premedication.)

AIDS/HIV positive	Y	N	Heart Attack/Heart Failure	Y	N
Anemia	Y	N	Heart Pacemaker	Y	N
Angina	Y	N	*Heart Disease	Y	N
Arthritis	Y	N	Hepatitis, type _____	Y	N
*Artificial Heart Valve	Y	N	High Blood Pressure	Y	N
*Artificial Joint: hip, knee, etc.	Y	N	Kidney Problems	Y	N
Asthma	Y	N	Liver Disease	Y	N
Bulimia/Anorexia	Y	N	Low Blood Pressure	Y	N
Cancer	Y	N	**Osteoporosis (weak bones)	Y	N
Chemotherapy	Y	N	*Organ Transplant	Y	N
Chest Pains	Y	N	which organ?_____		
Fever Blisters/Cold Sores	Y	N	Pain in Jaw Joints	Y	N
*Congenital Heart Disorder	Y	N	Parathyroid Disease	Y	N
Diabetes	Y	N	Radiation Treatment	Y	N
Drug Addiction	Y	N	Reflux Disease (GERD)	Y	N
Epilepsy/Seizures	Y	N	Sinus Problems	Y	N
Excessive Bleeding	Y	N	Stroke	Y	N
Fainting/Dizziness	Y	N	Tuberculosis	Y	N
Glaucoma	Y	N	Ulcers in the Mouth	Y	N

Please list any other medical problems: _____

_____

**Do you take or have you taken FOSAMAX, BONIVA, ACTONEL, DIDRONEL, AREDIA, ZOMETA, or any other bisphosphonate for osteoporosis (weak bones)? How long?_____ Y N

Are you taking any medications, pills or drugs, including over-the-counter drugs? Y N

If yes, please list by drug name, dosage and frequency:

_____

_____

_____

Do you use controlled substances? Y N

Are you allergic to any medications or foods? Y N

If yes, please check or list: ___aspirin ___penicillin ___latex ___metals
___peanuts ___tree nuts Other: _____

Are you under a physician's care now? Y N

If yes, please give the name, address and phone number of your physician(s):

_____

_____

_____

Women: Are you pregnant or trying to get pregnant? Y N

PATIENT SIGNATURE _____
(or parent/guardian if a minor)

Reviewed and updated: (TO BE FILLED OUT *AT FUTURE APPOINTMENTS ONLY*)

Initial: _____ date: _____	Initial: _____ date: _____	Initial:_____ date:_____
Initial: _____ date: _____	Initial: _____ date: _____	Initial: _____ date: _____
Initial: _____ date: _____	Initial: _____ date: _____	Initial:_____ date:_____
Initial: _____ date: _____	Initial: _____ date: _____	Initial: _____ date:_____