



MEDICAL HISTORY

DATE OF BIRTH _____

PATIENT'S NAME _____

MEDICAL DOCTOR _____

ACCOUNT # _____

DATE OF LAST PHYSICAL EXAM _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

List all <u>medications</u> , <u>herbal remedies</u> , and <u>nicotine replacement therapy</u> you are taking, including <u>over-the-counter</u> :	List all substances you are allergic to:

Do you now have, OR have you ever had, any of the following? Circle 'Y' for yes or 'N' for no

AIDS	Y / N	Epilepsy / Seizures	Y / N	Joint replacement	Y / N
Anemia	Y / N	Fen-Fen Redux	Y / N	Kidney disease	Y / N
Anxiety Disorder	Y / N	Gastro-esophageal reflux disease	Y / N	Liver disease	Y / N
Arthritis	Y / N	Glaucoma	Y / N	Psychiatric treatment	Y / N
Artificial heart valves	Y / N	Heart murmur	Y / N	Pacemaker	Y / N
Asthma	Y / N	Heart surgery	Y / N	Sensitivity to metals or latex	Y / N
Bisphosphonates (Fosamax)	Y / N	Heart trouble	Y / N	Sexually transmitted diseases	Y / N
Osteoporosis treatment	Y / N	Hepatitis type _____	Y / N	Sinus trouble	Y / N
Cancer or tumor	Y / N	High blood pressure	Y / N	Stroke	Y / N
Diabetes	Y / N	HIV positive	Y / N	Tuberculosis	Y / N

- Have you been treated by a physician or hospitalized in the past year? _____ Yes No
If Yes, explain: _____
- Has there been any change in your general health in the past year? _____ Yes No
If Yes, what? _____
- Are you experiencing any unresolved stress? _____ Yes No
- Have you had any unusual reaction to "novocaine" or local anesthetic? _____ Yes No
- Have you ever had problems with prolonged bleeding from a cut, injury, or tooth extraction? _____ Yes No
- Are you in a substance abuse recovery program? _____ Yes No
- Have you ever used, or are you currently using any narcotic **or** recreational drugs? _____ Yes No
- Are you pregnant or possibly pregnant? **If Yes**, when due? _____ Yes No
- Are you taking birth control pills or other hormones? _____ Yes No
- Is there anything related to your medical history that you have not indicated above? _____ Yes No
If Yes, explain: _____
- Have you ever used, or are you currently using, Tobacco? _____ Yes No
How often per day? _____ Start or Quit Date? _____ Would you like to stop? Yes No
- What is the usual amount of alcohol you consume per day _____, per week _____, per month _____

PATIENT / Guardian Signature _____ **Date** _____

**Patient: Please complete the back side of this form. **

Provider Signature / Date / Comments	
Provider Signature / Date / Comments	Provider Signature / Date / Comments
Provider Signature / Date / Comments	Provider Signature / Date / Comments

ASA	Antibiotic Pre-med	Allergies	Hepatitis	Heart Condition	Medication	Anesthetic	Other (specify)	Other (specify)
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DENTAL HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Please list your dental complaints or concerns, if any. _____

2. What do you want to accomplish in terms of your oral health? _____
3. Are you having any pain or discomfort at this time? Yes No
4. How do you presently take care of your teeth and gums? Flossing Yes No
 Toothbrush: Hard Soft Power How often per day? _____
5. Do you have sensitive teeth? If so, when: _____ Yes No
6. When was your last visit to a dentist? _____
7. What services were provided? _____
8. Who was your former dentist? _____ City / State: _____
9. How did you hear about us? _____
10. Would you like to learn how to prevent tooth decay and control gum disease? Yes No

GENERAL RISK - SELF ASSESSMENT:

11. Does your mouth seem dry? Yes No
12. During the day, do you eat and snack on sugary foods, drinks, gum, or mints? Yes No
13. Are you nervous about having dental treatment? Yes No
14. Have any of your family members had gum disease? Yes No
15. Have any of your family members had excessive cavities? Yes No

PERIODONTAL RISK - SELF ASSESSMENT:

16. Have you had, or have you ever been told that you have "gum disease," "deep pockets," or periodontal disease? Yes No
17. Currently, do you have sore or bleeding gums? Yes No

CARIES RISK - SELF ASSESSMENT:

18. Do you seem to have new cavities at each dental check-up? Yes No
19. Do you use xylitol or fluoride toothpaste? Yes No Do you use xylitol or fluoride rinses? Yes No
20. Do you live in an area with fluoridated water? Yes No
21. Have you had a lot of "fillings"? Yes No How long ago did you have your last filling? _____

****Patient: Please do not write below this line.****

PROVIDER COMMENTS:

Dr or RDH Signature _____ Date _____