Patient Name: _____

MEDICAL & DENTAL HISTORY

Medical Physician Name: _____ Office Phone No. _____

Previous Dentist Name: _____

How long has it been since your last cleaning & exam? ❑ 6-12 months ❑ 1-2years ❑ 2 years or more

1. Are you allergic to any of the following? **If yes, check box; otherwise leave blank.**

❑ Penicillin/Amoxicillin ❑ Local Anesthetic:_____ ❑ Metal: (Nickel, etc.) _____ __
❑ Keflex ❑ Epinephrine ❑ Other:
❑ Sulfa ❑ Latex _____

If yes to any of the following, check box; otherwise leave blank.

2. ❑ Are you taking any medications?
   If yes, list medications: _____
   _____
   _____
   _____
3. ❑ Do you require any pre-medication prior to dental treatment?
4. ❑ Have you ever been hospitalized for any surgical operation or serious illness within the past 5 years?
   If yes, identify: _____
5. ❑ Do you smoke?
6. ❑ Do you chew tobacco?
7. ❑ Do you drink alcohol?
8. ❑ Do you use any other drugs?
9. ❑ Have you had a panoramic (full mouth) x-ray taken within the last 3 years?
10. ❑ Have you had cavity detection (bitewing) x-rays taken within the last year?
11. ❑ Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

WOMEN ONLY

12. ❑ Are you Pregnant?
13. ❑ Are you taking birth control medication?

13. Have you had or do you currently have any of the following conditions?
If yes, check past or current box; otherwise leave blank.

Past	Current		Past	Current		Past	Current	
❑	❑	Rheumatic Fever	❑	❑	Diabetes: ❑ Type 1 ❑ Type 2 Controlled by: ❑ Diet ❑ Medication ❑ Insulin	❑	❑	Low Blood Pressure
❑	❑	Heart Murmur				❑	❑	High Blood Pressure
❑	❑	Heart Attack				❑	❑	Seizures
❑	❑	Heart Disease				❑	❑	Epilepsy
❑	❑	Angina	❑	❑	Cancer Type: _____ Treatment: ❑ Radiation ❑ Chemo ❑ Surgery	❑	❑	Stroke
❑	❑	Cardiac Pacemaker				❑	❑	Arthritis
❑	❑	Heart Valve Replacement				❑	❑	Hepatitis: A, B, or C (circle one)
❑	❑	Thyroid Disease						
❑	❑	Kidney Disease	❑	❑	Asthma	❑	❑	AIDS or HIV Infection
❑	❑	Liver Disease	❑	❑	Respiratory Problems	❑	❑	Joint Replacement
❑	❑	Anemia	❑	❑	Hay Fever/Allergies	If yes, which joint? _____		
❑	❑	Other: _____						

If yes to any of the following, check box; otherwise leave blank.

14. ❑ Do your gums bleed while brushing or flossing?
15. ❑ Are your teeth sensitive to hot or cold liquids/foods?
16. ❑ Are your teeth sensitive to sweet or sour liquids/foods?
17. ❑ Do you feel pain in any of your teeth?
18. ❑ Do you have any sores or lumps in or near your mouth?
19. ❑ Have you ever had any head, neck or jaw injuries?
20. ❑ Have you ever experienced any of the following problems in your jaw?
    - ❑ A) Clicking
    - ❑ B) Pain (Joint, Ear, Side of Face)
    - ❑ C) Difficulty in opening or closing?
    - ❑ D) Difficulty in chewing?
21. ❑ Do you have frequent headaches?
22. ❑ Do you clench or grind your teeth?
23. ❑ Do you bite your lips or cheeks frequently?
24. ❑ Have you ever had any difficult extractions in the past?
25. ❑ Have you had any orthodontic treatment?
26. ❑ Have you ever had prolonged bleeding following extractions?
27. ❑ Have you ever had instruction on the correct method of brushing your teeth and care of your gums?
28. ❑ Do you have any dental cosmetic concerns?
    ❑ Color of Teeth ❑ Teeth Alignment
29. ❑ Have you bleached/whitened your teeth before?
30. ❑ Are you interested in: ❑ Bleaching/Whitening ❑ Veneers ❑ Straighter Teeth

If none of the above boxes have been checked, please initial____