Patient Name: _____

MEDICAL AND 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?

WOMEN ONLY

11. ❑ Are you Pregnant?

12. ❑ 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:	❑	❑	Low Blood Pressure
❑	❑	Heart Murmur			❑ Type 1 ❑ Type 2	❑	❑	High Blood Pressure
❑	❑	Heart Attack			Controlled by:	❑	❑	Seizures
❑	❑	Heart Disease			❑ Diet ❑ Medication ❑ Insulin	❑	❑	Epilepsy
❑	❑	Angina	❑	❑	Cancer	❑	❑	Stroke
❑	❑	Cardiac Pacemaker			Type: _____	❑	❑	Arthritis
❑	❑	Heart Valve Replacement			Treatment:	❑	❑	Hepatitis: A, B, or C (circle one)
❑	❑	Thyroid Disease			❑ Radiation ❑ Chemo ❑ Surgery			
❑	❑	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____