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|---------------------------|---------------------|
| Patient Name _____ | Medical History |
| Patient Account No. _____ | Medical Alert _____ |

1. Have you been under the care of a medical doctor during the past two years? _____ Yes No

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ ST _____ Zip _____

2. Have you taken any medication or drugs during the past two years? _____ Yes No

3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the counter herbal medicines? _____ Yes No

If yes, please list name and dosage _____

4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimin (fenfluramine); and Redux (dexfenfluramine)? _____ Yes No

If yes to the above, did you have a medical exam for heart issues? _____ Yes No

5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? _____ Yes No

If yes, please list: _____

6. Have you been a patient in the hospital during the past five years? _____ Yes No

7. Indicate which of the following you have had, or have at present. Check "yes" or "no" to each item.

- | | | | | | |
|-------------------------------------|--|--------------------|--|--------------------------------|--|
| Heart (Surgery, Disease, Attack) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A B C (Circle) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Veneral Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | A.I.D.S. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | H.I.V. Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Contact Lenses | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Sensitivity | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swollen Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies or Hives | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diet (Special/Restricted) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints (hip, knee, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous/Anxious | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/Psychological Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |

8. Do you use more than two pillows to sleep? _____ Yes No

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

10. Do you have or have you had any disease, condition, or problem not listed? _____ Yes No

If yes, please list: _____

11. Women: Are you pregnant or think you may be pregnant? Yes _____ Months No Nursing? Yes No

12. Women: Do you use birth control medications? _____ Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature _____ Date: _____

Dentist Signature _____ Date: _____

Please complete both sides

| | |
|---------------------------|-----------------------|
| Patient Name _____ | Dental History |
| Patient Account No. _____ | Medical Alert _____ |

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form
All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-Rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ City _____ ST _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick etc.) _____

Do you have any dental problems now? _____ Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Have you ever had:

- Hot or cold? Yes No
- Sweets? Yes No
- Biting or chewing? Yes No
- Have you noticed any mouth odors or bad tastes? Yes No
- Do you frequently get cold sores blisters or
any other oral lesions? Yes No
- Do your gums bleed or hurt? Yes No
- Have your parents experienced gum disease
or tooth loss? Yes No
- Have you noticed any loose teeth or change
in your bite? Yes No
- Does food tend to become caught in between
your teeth? Yes No

- Orthodontic treatment? Yes No
- Oral Surgery? Yes No
- Periodontal treatment? Yes No
- Your teeth ground or the bite adjusted? Yes No
- A bite plate or mouth guard? Yes No
- A serious injury to the mouth or head? Yes No
- If so, please describe, including cause _____

If yes, where? _____

Do you:

Have you experienced:

- Clench or grind your teeth while awake or asleep? Yes No
- Bite your lips or cheeks regularly? Yes No
- Hold foreign objects with your teeth?
(Pencils, pipe, pins, nails, fingernails) Yes No
- Mouth breathe while awake or asleep? Yes No
- Have tired jaws, especially in the morning? Yes No
- Snore or have any other sleeping disorder? Yes No
- Smoke/chew tobacco or use other tobacco products? Yes No

- Clicking or popping of the jaw? Yes No
- Pain? (joint, ear, side of face) Yes No
- Difficulty in opening or closing the mouth? Yes No
- Difficulty in chewing on either side of the mouth? Yes No
- Headaches, neckaches or shoulder aches? Yes No
- Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern?

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? _____ Yes No

If yes, please describe _____