Dental History

Medical Alert?

Pt. Name: _____
(Last) (First)

What is the reason for today's visit?: _____

Date of Last Dental Visit: _____ Last Dental Cleaning: _____ Last X-Rays: _____

What was done at your last dental visit?: _____

Current Dentist: _____ Phone: ( )

Address: _____ State: _____ Zip: _____

How often do you see your dentist?: _____

How often do you:
Brush your teeth? _____ Floss? _____

Have you ever used topical flouride?
☐ Yes ☐ No

What other dental aids do you use?:
☐ electric toothbrush ☐ waterpik ☐ proxy-brush ☐ toothpick ☐ other dental cleaning aids (from dentist, etc)

Do you currently have any dental problems? ☐ Yes ☐ No

If yes, please describe: _____

Are any of your teeth sensitive to:	**Yes**	**No**
Hot or cold	☐	☐
Sweets	☐	☐
Biting or chewing	☐	☐

Do you have any problems with:	**Yes**	**No**
Mouth odors or bad tastes	☐	☐
Cold sores, blisters, or other oral lesions	☐	☐
Sore or bleeding gums	☐	☐
Gum disease or tooth loss	☐	☐
Loose teeth or change in your bite	☐	☐
Food getting caught between your teeth	☐	☐

Have you experienced:	**Yes**	**No**
Clicking or popping of the jaw	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing your mouth	☐	☐
Difficulty chewing on either side of your mouth	☐	☐
Headaches, neckaches or shoulder aches	☐	☐
Sore muscles in neck or shoulders	☐	☐
Are you satisfied with the appearance of your teeth?	☐	☐
Are you nervous about having orthodontic treatment?	☐	☐
Have you ever been told to take a pre-medication before a dental or orthodontic visit?	☐	☐

Have you ever had:	**Yes**	**No**
Orthodontic treatment	☐	☐
Periodontal treatment	☐	☐
Oral Surgery	☐	☐
A bite adjustment	☐	☐
A bite plate or mouth guard	☐	☐
A serious injury to the mouth or head	☐	☐

If yes, please describe, including cause _____

Do you:	**Yes**	**No**
Smoke/chew or other tobacco products	☐	☐
Clench or grind your teeth while awake or asleep	☐	☐
Bite your lips or cheecks regularly	☐	☐
Hold foreign objects with your teeth (ie. pens, pins, nails, fingernails, smoking pipe)	☐	☐
Mouth breathe while awake or asleep	☐	☐
Have tired jaws, especially in the morning	☐	☐
Snore or have any other sleeping disorders	☐	☐
Have you ever been told you have sleep apnea?	☐	☐
Do you take naps during the day?	☐	☐
Do you often feel tired during the day?	☐	☐
Has anyone noticed that you stop breathing during sleep?	☐	☐

Do you have any other concerns? _____

(please complete other side)

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Medical History

Medical Alert?

Pt. Name: _____
(Last) (First)

Physician's name: _____

Phone Number: ( )

	Yes	No
Have you had any medical care in the past two years? (please describe)	☐	☐
Have you taken any medication or drugs during the past two years?	☐	☐
Are you currently taking any medication, drugs, or alternative remedies (herbal), including asprin, regularly? If yes, please list with dosage:		
Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Bonica or other similar drugs?	☐	☐
Are you aware of any allergies or adverse reactions to any substance or medication? Please specify:		
Have you been a patient in a hospital in the past five years?	☐	☐

If yes, why? _____

Have you had, or do you currently have any of the conditions listed below? Please check yes or no.

	Yes	No		Yes	No		Yes	No
Heart surgery, disease, attack	☐	☐	Ulcers	☐	☐	Hepatitis A B C (circle)	☐	☐
Chest pain	☐	☐	Diabetes	☐	☐	Veneral Disease	☐	☐
Congenital heart disease	☐	☐	Thyroid problems	☐	☐	A.I.D.S./H.I.V. positive	☐	☐
Heart murmur	☐	☐	Glaucoma	☐	☐	Cold Sores	☐	☐
High/low blood pressure	☐	☐	Contact lenses	☐	☐	Blood transfusion	☐	☐
Mitral valve prolapse	☐	☐	Emphysema	☐	☐	Hemophilia	☐	☐
Artificial heart valve/pacemaker	☐	☐	Chronic cough	☐	☐	Sickle cell disease	☐	☐
Rheumatic fever	☐	☐	Tuberculosis	☐	☐	Bruise easily	☐	☐
Arthritis/Rheumatism	☐	☐	Asthma	☐	☐	Liver Disease/Jaundice	☐	☐
Cortisone medicine	☐	☐	Seasonal allergies	☐	☐	Neurological dissorders	☐	☐
Swollen ankles	☐	☐	Latex sensitivity	☐	☐	Epilepsy or seizures	☐	☐
Stroke	☐	☐	Sinus trouble	☐	☐	Fainting or dizzy spells	☐	☐
Special/Restricted diet	☐	☐	Radiation therapy	☐	☐	Anxiety/Nervousness	☐	☐
Artificial joints	☐	☐	Chemotherapy	☐	☐	Psychiatric/Psychological Care	☐	☐
Kidney trouble	☐	☐	Tumors	☐	☐			

Have you lost or gained more than 10 pounds in the past year?	☐	☐
Do you have any other medical condition you would like us to know about?		

Women:

Are you, or do you think you could be pregnant (if yes, list months _____)	☐	☐
Do you currently use perscription birth control	☐	☐

i understand that the information provided on this form is necessary to provide me with safe efficient orthodontic care. I have answered all questions to the best of my knowledge. Should further information be required, this office has my permission to ask the respective health care provider or agency, who may release such information to this office. I will notify this office of any change in my health or medication.

Patient/Guardian Signature: _____ Date: _____

(please complete other side)

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