

MEDICAL HISTORY
Name:
D.O.B:
AGE:

If you are completing this form for another person, what is your relationship to that person?

Your Name:

Relationship:

Physician name :

Physician phone number:

PLEASE ANSWER THE FOLLOWING QUESTIONS BY INDICATING YES OR NO:

Are you in good health?	Yes	No
Has there been any change in your general health within the past year?	Yes	No
Are you under a physician's care or currently under medical treatment? If yes, describe: _____	Yes	No
Have you been hospitalized/had major surgery/serious illness in the last five years? If yes, describe: _____	Yes	No
Have you ever had excessive bleeding following an extraction, or had other bleeding problems?	Yes	No
WOMEN: Are you or could you be pregnant? Due date: / /	Yes	No
WOMEN: Are you nursing?	Yes	No
WOMEN: Do you take hormonal replacement medications?	Yes	No
Do you take any prescriptions and/or over the counter medications? If yes, list all dosages and frequency of medications taken, including vitamins, natural/herbal preparations and/or diet supplements: _____ _____ _____ _____	Yes	No
Do you use tobacco in any form? If yes, in what form and much: _____ If you use tobacco, how interested are you in stopping? Very/Somewhat/Not Interested	Yes	No
Do you consume alcoholic beverages (more than two drinks a day)?	Yes	No
Do you use recreational drugs?	Yes	No
Have you taken Fosamax, Bonvia, Actonel, or medications containing bisphosphonates?	Yes	No
Has any physician or dentist recommended that you take antibiotics prior to dental treatment? If yes, for what?	Yes	No

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO:

Local Anesthetics	Yes	No	Barbiturates/sedatives/sleeping pills	Yes	No
Penicillin or other antibiotics	Yes	No	Sulfa	Yes	No
Aspirin	Yes	No	Codeine/other narcotics	Yes	No
Latex (rubber)	Yes	No	Food If yes, what? _____	Yes	No
Any other allergies If yes, describe: _____	Yes	No		Yes	No

DO YOU HAVE ANY OF THE FOLLOWING DISEASES OF PROBLEMS?

Active tuberculosis	Yes	No	Cough that produces blood	Yes	No
Persistent cough greater than a 3 week duration	Yes	No	Been exposed to anyone with tuberculosis	Yes	No

DENTAL HISTORY

Patient Name:	D.O.B. :	Age:
Date of last dental visit: / /	Date of last cleaning: / /	Date of last x-rays: / /
How often do you visit a dentist?	How often do you have your teeth cleaned?	
Dentist's Name: (First and Last)	Dentist's Phone #:	

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:

Gum Disease	Yes	No	Injuries to Jaw/Head/Neck	Yes	No
Loose Teeth	Yes	No	Dry Mouth	Yes	No
Bleeding/Sore Gums	Yes	No	Shifting of Teeth/Change in Bite	Yes	No
Bleeding when Brushing or Flossing	Yes	No	Unpleasant Taste/Bad Breath	Yes	No
Clicking/Popping/Pain in Jaw	Yes	No	Biting Cheeks/Lips	Yes	No
Burning Tongue/Lips	Yes	No	*Periodontal Treatment/Gum Surgery	Yes	No
Swollen/Painful Gums	Yes	No	*Oral Surgery	Yes	No
Difficulty/Pain upon Opening Jaw	Yes	No	*Orthodontic Treatment/Braces	Yes	No
Clenching/Grinding	Yes	No	*Endodontic Treatment/Root Canal	Yes	No
Frequent Blisters or Cold Sores	Yes	No	*Treatment for TMJ Problems	Yes	No
Sensitivity to Cold/Sweets/Pressure	Yes	No	Chewing Difficulty	Yes	No
Change in Occlusion/Bite	Yes	No	Food Lodging Between Teeth	Yes	No
*Please Explain:					

DO YOU HAVE ANY OF THE FOLLOWING HABITS?

Grind/Clench Teeth	Yes	No	Bite Fingernails	Yes	No
Mouth Breathing While Awake/Sleep	Yes	No	Hold Objects with Teeth	Yes	No

DENTAL INFORMATION:

Do you wear dentures/partials?	Yes	No	If yes, specify:
Do you drink bottled/filtered water?	Yes	No	If yes, how often?
Is your water supply fluoridated?	Yes	No	
Have you had any problems associated with previous dental treatment?	Yes	No	If yes, please explain:

DO YOU USE THE FOLLOWING?

Toothbrush (Soft, Medium, or Hard)	Yes	No	How often do you brush?
Dental Floss	Yes	No	How often do you floss?
Fluoride Rinse	Yes	No	What type and how often?
Other Dental Aids	Yes	No	If yes, what type?

WHAT ARE YOUR DENTAL CONCERNS?

To the best of my knowledge, the above information is complete and correct.

Date:	Patient Signature:	Faculty Signature:	Student Signature:
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****THIS FORM MUST BE COMPLETED ANNUALLY**