# MEDICAL AND DENTAL HISTORY

Previous Dentist(s): ______________________ Date of Last Dental Cleaning: __________
Current Physician(s): ______________________ Date of Last Physical Exam: __________

All past medical and dental history may be important for your optimal care. Please take time to be as accurate and thorough as possible in answering the following questions (use bottom of page if necessary). THANK YOU.

- Please list your chief concerns for treatment: ______________________
- Describe anything that bothers you about the appearance of your teeth, smile, or face: ______________________
- Please list all previous surgeries or hospitalizations: ______________________

Please √ if you have or had in the past any of the following conditions:

**MEDICAL**

- High Blood Pressure ☐
- Chest pains or heart attack ☐
- Stroke ☐
- Rheumatic Fever ☐
- Shortness of breath or swollen ankles ☐
- Any heart trouble, murmur, or mitral valve prolapse ☐
- Prosthetic devices (heart, valve, hip, etc.) ☐
- Any lung disease (T.B., emphysema, etc.) ☐
- Asthma ☐
- Allergies or hay fever ☐
- Sinus Problems ☐
- Mouthbreathing or excessive snoring ☐
- Ulcers or stomach problems ☐
- Diabetes ☐
- Hepatitis or liver disease ☐
- Kidney or bladder disease ☐
- Thyroid trouble ☐
- Connective tissue disease ☐
- Sexually transmitted disease ☐
- Arthritis or rheumatism ☐
- Cancer (type, date) ☐
- Serious illnesses no listed (list-type, date) ☐
- Subject to prolonged bleeding or bruise easily ☐
- A contact lens user ☐
- Glaucoma ☐
- Epilepsy, convulsions or seizures ☐
- Psychiatric therapy or emotional problems ☐
- Do you have HIV (AIDS)? ☐
- Have you been exposed to HIV? ☐
- Have you been tested for HIV? ☐

- Pregnant or possible pregnant ☐
- Taking birth control pills ☐
- Drink coffee (cups per day) ☐
- Use tobacco (types/how much) ☐
- Consume alcoholic beverages ☐
- Pain, popping, catching or locking in jaw joints ☐
- Clench or grind your teeth ☐
- Wake up with sore jaws ☐
- Frequent headaches (How many per week?___) ☐
- Dizziness, ringing or pain in ears ☐
- Tenderness or stiffness in the jaw, neck or back ☐
- History of TMJ (jaw joint) problems or therapy ☐

**DENTAL**

- Treated for or told you have gum disease ☐
- Treated or consulted for orthodontic thearpy ☐
- Had any oral surgery ☐
- Dental x-rays taken in last year ☐
- Excessive fear of dental treatment ☐
- Brush your teeth (how often?) ☐
- Floss your teeth (how often?) ☐
- Bad breath or unpleasant taste in your mouth ☐
- Bleeding gums ☐
- Sore teeth ☐
- Tooth sensitivity (hot, cold, sweets, biting) ☐
- Fever blisters of mouth ulcers ☐
- Suck your thumb, finger, or lip ☐
- Tongue thrusting habit ☐

## MEDICATIONS

Please list all medications you are taking:

______________________

## ALLERGIES

Please √ any medications you are allergic to:

☐ Aspirin ☐ Penicillin ☐ Sulfa
☐ Codeine ☐ Local Anesthetic ☐ Other____

The above information is accurate and complete to the best of my knowledge:

Date:________ Patient or Guardian's Signature:______________ Doctor's Signature:__________
Updated:________ Por G's Initials:________ Doctor's Initials:______;______;______;______;______;______