**PATIENT NAME**

# Dental History

**PATIENT ACCOUNT NO.** **MEDICAL ALERT**

SCHMITT & MIDKIFF
GENERAL DENTISTRY

*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 State Zip

**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? (electric toothbrush, toothpick, etc.)

**Do you have any dental problems now?** YES NO

If yes, please describe:

**Are any of your teeth sensitive to:**

YES NO 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?
If yes, where?_____

**Do you?**

YES NO 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 Smoke/chew tobacco?

**Have you ever had:**

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?
If yes, please describe, including cause_____

**Have you experienced?**

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 of your life?
YES NO Do you feel nervous about having dental treatment?
If so, what is your biggest concern?_____

YES NO Have you ever had an upsetting dental experience?
If so, please describe_____

**Is there anything else about having dental treatment that you would like us to know?** **YES** **NO**

If so, please describe_____

# Medical History

**PATIENT NAME**

**PATIENT ACCOUNT NO.** **MEDICAL ALERT**

YES NO 1. Have you been under the care of a medical doctor during the past two years?
If yes, for what?_____
Physician's name_____ Phone_____
Address_____ City_____ State_____ Zip_____

YES NO 2. Have you taken any medication or drugs during the past two years?

YES NO 3. Are you taking any medication, drugs or pills now?
If yes, please list names and dosage_____

YES NO 4. Have you ever taken prescription medications for weight loss (diet pills)?
If yes, did you take any of the following:

YES NO Fen-Phen (Fenfluramine-Phenpermine)

YES NO Pondimen (Fenfluramine)

YES NO Redux (Dexfenfluramine)

YES NO If yes to any of 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?
If yes, please list:_____

YES NO 6. Have you been a patient in the hospital during the past five years?

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

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

YES 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?
If yes, please list_____

11. **Women.** Are you: **Pregnant?** YES, _____ Months NO **Nursing?** YES NO **Taking birth control pills?** 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 doctor of change in my health or medication.

Parent/Guardian Signature_____ Date_____

## History Review

Dentist's Signature_____ Date_____