PATIENT NAME: ______________________ BIRTH DATE: ________

MEDICAL HEALTH HISTORY

Do you have--or have you had--any of the following? (Please check all that apply)

- ☐ Abnormal bleeding after extractions, surgery or trauma
- ☐ AIDS or HIV positive
- ☐ Alcohol/drug dependency
- ☐ Allergies or hives
- ☐ Anemia or blood disorders
- ☐ Arthritis/rheumatism
- ☐ Artificial heart valve
- ☐ Artificial joint -Type: ____________________
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Bone disorders
- ☐ Cancer or tumor -Type: ____________________
- ☐ Chemotherapy
- ☐ Congenital heart problems
- ☐ Diabetes (insulin/diet controlled)
- ☐ Digestive disorders/acid reflux
- ☐ Emotional problems ☐ Anxiety ☐ Depression
- ☐ Epilepsy, seizures or fainting spells
- ☐ Glaucoma
- ☐ Hay fever or sinus trouble
- ☐ Head or neck injuries
- ☐ Hearing problems
- ☐ Heart ailment or angina
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Heart pacemaker
- ☐ Hepatitis/jaundice/or other liver disease
- ☐ Herpes or cold sores
- ☐ High blood pressure ☐ Low blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Lung or breathing problems
- ☐ Migraine headaches or frequent headaches
- ☐ Multiple sclerosis
- ☐ Neurologic condition
- ☐ Neuromuscular disease
- ☐ Osteoporosis
- ☐ Psychiatric treatment
- ☐ Radiation therapy
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Sexually transmitted disease
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid or parathyroid problems
- ☐ Ulcers

Is premedication required for treatment? ☐ **Yes** ☐ **No**

Medication taken for premedication: ________________

Are you allergic to--or have you reacted adversely to--any of the following?

- ☐ Antibiotics
- ☐ Aspirin or ibuprofen
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Codeine or other narcotics
- ☐ Latex materials
- ☐ Local anesthetics ("Novocain")
- ☐ Nut allergy
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Tetracycline
- ☐ Other: ______________________________

Please list all medications you are taking: ____________

____
____
____
____
____
____
____
____
____

Are you taking any of the following? (Check all that apply)

- ☐ Antibiotics or sulfa drugs
- ☐ Anticoagulants (blood thinners)
- ☐ Antidepressants or tranquilizers
- ☐ Aspirin
- ☐ Cortisone or other steroids
- ☐ High blood pressure medicine
- ☐ Insulin or other diabetes drug
- ☐ Nitroglycerin
- ☐ Osteoporosis (bone density) medicine

Do you smoke or use chewing tobacco? ☐ **Yes** ☐ **No**

Women:

- ☐ May be pregnant
  Expected delivery date: ____________
- ☐ Taking hormones or contraceptives

Name of your physician: ____

Do you have any disease or condition not listed above? ____________________________

Have you been hospitalized in the last five years? Please explain: ____________________

____

Please add anything else you would like us to know about: ____________________

____

Reviewed: ______________________ **Date**: ____________

Reviewed: ______________________ **Date**: ____________

Weston Smiles
DENTAL

DENTAL HISTORY

Last Dental Treatment_______________________________ Last Dental X-rays_________________________________

Previous Dentist_____________________________________ How long with this dentist__________________________

How often are your teeth cleaned?____

Please answer by circling YES or NO to the following:

YES	NO	Is there anything you would like to change about the look or feel of your teeth?
YES	NO	Dental fears or unfavorable experiences?
YES	NO	Problems with effectiveness or bad reactions to dental anesthetics?
YES	NO	Orthodontic treatment? (Date___________)
YES	NO	Periodontal (gum) treatment?
YES	NO	Avoid brushing any part of your mouth?
YES	NO	Have gums that bleed when brushing or flossing?
YES	NO	Have teeth that are sensitive to hot or cold?
YES	NO	Have sore or painful teeth?
YES	NO	Have a burning sensation in your mouth?
YES	NO	Have difficulty swallowing?
YES	NO	Have an unpleasant taste or odor in your mouth?
YES	NO	Dry mouth, throat, and/or eyes?
YES	NO	Jaw problems (temporomandibular joint)?
YES	NO	Difficulty in opening your mouth widely?
YES	NO	Stiff neck muscles?
YES	NO	Awaken with an awareness of your teeth or jaw?
YES	NO	Have tension headaches?
YES	NO	Clench or grind your teeth?
YES	NO	Lost any teeth?
YES	NO	Wear a bite splint, night guard, orthodontic retainer, or sleep apnea appliance?
YES	NO	Sores or growths in your mouth?
YES	NO	Loose teeth or broken fillings?
YES	NO	Food collection between teeth?

How often do you brush?_____________________________

How often do you floss?______________________________

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a removable partial or complete denture, please complete the following:

YES NO Has your present denture been relined? When?___________________________

YES NO Is your present denture a problem? Describe_________________________

____

____

____

YES NO Are you satisfied with the appearance?

YES NO Are you satisfied with the comfort?

When did you receive your first partial or complete denture?_________________________

How long have you worn your present denture?__________________________________

Patient Signature (parent/guardian)____________________________________ **Date**____________________________

Doctor's Signature____ **Date**____________________________

*Reviewed*__________________________________ *Date*_____________

*Reviewed*__________________________________ *Date*_____________