



Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Dental History**

*To assist us in understanding your dental condition and experiences, would you please answer the following questions? If you have any doubts about the information requested please ask the doctor.*

**HAVE YOU EVER HAD THE FOLLOWING TREATMENT:**

- 1. Orthodontics (straightening of your teeth).....Yes No  
As a child \_\_\_\_, or adult \_\_\_\_. happy \_\_\_\_, or unhappy \_\_\_\_ with result.
- 2. Extractions..... Yes No  
How long ago \_\_\_\_\_ Reason for extraction \_\_\_\_\_
- 3. Periodontal treatment (gum treatment)..... Yes No
- 4. Mouth guard or splint (plastic device between your teeth)..... Yes No
- 5. Treatment or surgery to change bite..... Yes No
- 6. Over the past five years how often have you been seen for teeth cleanings?

- 7. \_\_\_\_\_  
The date of your last visit to a dentist: \_\_\_\_\_  
That dentist's name: \_\_\_\_\_
- 8. Would you change anything about your teeth or smile?..... Yes No  
What? \_\_\_\_\_

**ARE YOU AWARE OF ANY OF THE FOLLOWING CONDITIONS:**

- 9. Sores, lumps or irritated areas in your mouth..... Yes No
- 10. Food catching or collecting between your teeth..... Yes No
- 11. Clenching or grinding your teeth..... Yes No
- 12. Clicking, popping or grating noise in your jaw when chewing.... Yes No
- 13. Numbness or tingling in your mouth or face..... Yes No
- 14. Do your gums bleed when brushing..... Yes No
- 15. Chronic neck or shoulder pain..... Yes No
- 16. Aches or pain in the side of your face..... Yes No
- 17. Any history of injuries to the face, mouth, or teeth. Yes No  
If yes, please describe \_\_\_\_\_
- 18. Have your tonsils and adenoids been removed?..... Yes No
- 19. Have you ever sucked a thumb or finger?.....Yes No
- 20. Do you have any speech problems?..... Yes No
- 21. Are you a mouth breather?..... Yes No
- 22. Do you play a musical wind instrument?..... Yes No
- 23. Has the eruption time of your teeth seemed normal?..... Yes No  
Early \_\_\_\_\_ Late \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Medical History Form

*Thank you for taking the time to provide us with this essential information. It will be used each time to select the safest and most effective means of providing you with dental care. Of course, all information on this form is completely confidential.*

1. Are you in good health? ..... Yes \_\_\_ No \_\_\_
2. Has there been any change in your general health within the past year? ..... Yes \_\_\_ No \_\_\_  
If yes, what? \_\_\_\_\_
3. Are you now under the care of a physician? ..... Yes \_\_\_ No \_\_\_  
If so, what is the condition being treated? \_\_\_\_\_
4. The name of my physician(s) is (are) \_\_\_\_\_
5. Have you had any serious illness, operation, or been hospitalized in the past 5 yrs? Yes \_\_\_ No \_\_\_  
If so, what was the nature of your illness? \_\_\_\_\_
6. Are you taking any medicine including non-prescription medicine? ..... Yes \_\_\_ No \_\_\_  
Medicine \_\_\_\_\_ Taken For \_\_\_\_\_ / Medicine \_\_\_\_\_ Taken For \_\_\_\_\_  
Medicine \_\_\_\_\_ Taken For \_\_\_\_\_ / Medicine \_\_\_\_\_ Taken For \_\_\_\_\_
7. Do you have or have you had any of the following diseases or problems:
  - a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease? ..... Yes \_\_\_ No \_\_\_
  - b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) Yes \_\_\_ No \_\_\_
    1. Do you have chest pain upon exertion? ..... Yes \_\_\_ No \_\_\_
    2. Are you ever short of breath after mild exercise or when lying down? ..... Yes \_\_\_ No \_\_\_
    3. Do your ankles swell? ..... Yes \_\_\_ No \_\_\_
    4. Do you have inborn heart defects? ..... Yes \_\_\_ No \_\_\_
    5. Do you have a cardiac pacemaker? ..... Yes \_\_\_ No \_\_\_
  - c. Environmental Allergies? (mold, dust, pollen, animals, food, latex?) Yes \_\_\_ No \_\_\_  
Please specify \_\_\_\_\_
  - d. Sinus trouble ..... Yes \_\_\_ No \_\_\_
  - e. Asthma or hay fever ..... Yes \_\_\_ No \_\_\_
  - f. Fainting spells or seizures ..... Yes \_\_\_ No \_\_\_
  - g. Persistent diarrhea or recent weight loss ..... Yes \_\_\_ No \_\_\_
  - h. Diabetes, excessive thirst or frequent urination ..... Yes \_\_\_ No \_\_\_
  - i. Hepatitis, jaundice, or liver disease ..... Yes \_\_\_ No \_\_\_
  - j. AIDS or HIV infection ..... Yes \_\_\_ No \_\_\_
  - k. Thyroid problems ..... Yes \_\_\_ No \_\_\_
  - l. Respiratory problems, emphysema, bronchitis, etc. .... Yes \_\_\_ No \_\_\_
  - m. Arthritis or painful swollen joints ..... Yes \_\_\_ No \_\_\_
  - n. Stomach ulcer or hyperacidity ..... Yes \_\_\_ No \_\_\_
  - o. Kidney trouble ..... Yes \_\_\_ No \_\_\_
  - p. Tuberculosis ..... Yes \_\_\_ No \_\_\_
  - q. Persistent cough or cough that produces blood. .... Yes \_\_\_ No \_\_\_
  - r. Persistent swollen glands in neck ..... Yes \_\_\_ No \_\_\_
  - s. Low blood pressure ..... Yes \_\_\_ No \_\_\_
  - t. Sexually transmitted disease ..... Yes \_\_\_ No \_\_\_
  - u. Epilepsy or other neurological disease ..... Yes \_\_\_ No \_\_\_
  - v. Problems with mental health, emotional tension, depression or anxiety ..... Yes \_\_\_ No \_\_\_
  - w. Cancer ..... Yes \_\_\_ No \_\_\_
  - x. Problems of the immune system ..... Yes \_\_\_ No \_\_\_
  - y. Frequent headaches ..... Yes \_\_\_ No \_\_\_
  - z. Often fatigued or exhausted ..... Yes \_\_\_ No \_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Medical History (Continued)

- 8. **Have you had abnormal bleeding?** ..... Yes \_\_\_\_ No \_\_\_\_
  - a. **Have you ever required a blood transfusion?** ..... Yes \_\_\_\_ No \_\_\_\_
- 9. **Do you have any blood disorder such as anemia?** ..... Yes \_\_\_\_ No \_\_\_\_
- 10. **Have you ever had any treatment for a tumor or growth?** ..... Yes \_\_\_\_ No \_\_\_\_
- 11. **Are you allergic or have you had a reaction to the following medicines:**
  - a. **Local anesthetics** ..... Yes \_\_\_\_ No \_\_\_\_
  - b. **Penicillin or other antibiotics** ..... Yes \_\_\_\_ No \_\_\_\_
  - c. **Sulfa drugs** ..... Yes \_\_\_\_ No \_\_\_\_
  - d. **Barbiturates, sedatives, or sleeping pills** ..... Yes \_\_\_\_ No \_\_\_\_
  - e. **Aspirin** ..... Yes \_\_\_\_ No \_\_\_\_
  - f. **Iodine** ..... Yes \_\_\_\_ No \_\_\_\_
  - g. **Codeine or other narcotics** ..... Yes \_\_\_\_ No \_\_\_\_
  - h. **Other**..... Please Specify \_\_\_\_\_
- 12. **Have you had any serious trouble associated with any previous dental treatment?** Yes \_\_\_\_ No \_\_\_\_  
If so, please explain \_\_\_\_\_
- 13. **Do you have any disease, condition, or problem not listed above that you think I should know about?** ..... Yes \_\_\_\_ No \_\_\_\_
- 14. **Are you wearing contact lenses?** ..... Yes \_\_\_\_ No \_\_\_\_
  - a. **Glaucoma test normal?** ..... Yes \_\_\_\_ No \_\_\_\_
- 15. **Are you wearing removable dental appliances?** ..... Yes \_\_\_\_ No \_\_\_\_
- 16. **Do you smoke?** (Packs per day \_\_\_\_\_) ..... Yes \_\_\_\_ No \_\_\_\_  
*(Women please continue)*
- 17. **Are you pregnant?** ..... Yes \_\_\_\_ No \_\_\_\_
- 18. **Do you have any problems associated with your menstrual period?** ..... Yes \_\_\_\_ No \_\_\_\_
- 19. **Are you nursing?** ..... Yes \_\_\_\_ No \_\_\_\_
- 20. **Are you taking birth control pills?** ..... Yes \_\_\_\_ No \_\_\_\_

**Chief Dental Complaint** \_\_\_\_\_

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for my errors or omissions that I may have made in the completion of this form.

X

Signature (Parent or Guardian if patient is a minor)

(The following to be completed by Dr. Bussa ) .....

Comments on patient interview concerning medical history: \_\_\_\_\_

Significant findings from questionnaire or oral interview: \_\_\_\_\_

Dental management considerations: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Dentist \_\_\_\_\_

Medical history update: \_\_\_\_\_