# Dental History

1. What is the reason for your dental visit today? _____

2. Date(s) of last dental visit: _____ Last dental cleaning: _____Last full mouth x-rays:_____

3. What was done at your last dental visit?_____

4. Who was your previous dentist/dental office? _____

*May we request your previous dental office for your records?* ***(Yes or No)***

5. How often do you brush your teeth? _____ Do you floss? *(Yes or No)*

6. Do you have any dental problems right now? _____

7. Do you have or have you ever had any of the following: ***(Check the box if it applies to you.)***

- □ sensitivity to hot or cold
- □ Sensitivity to sweets
- □ sensitivity to biting or chewing
- □ bad odors or tastes
- □ bleeding or sore gums
- □ swelling or lumps in mouth
- □ loose teeth or change in your bite
- □ food becoming lodged in between teeth
- □ clenching or grinding when awake or asleep
- □ clicking or jaw popping
- □ bite your lips or cheek regularly
- □ mouth breathe while awake or asleep
- □ have tired jaws, especially in the morning
- □ had orthodontic treatment (braces)
- □ oral surgery
- □ periodontal treatment
- □ splint or mouth guard
- □ serious head or mouth injury
- □ dry mouth
- □ joint pain in ears or side of face
- □ difficulty opening or closing
- □ difficulty chewing on either side of mouth
- □ frequent headaches, neck or shoulder aches
- □sore neck or shoulder muscles
- □ snore or have other sleeping disorder

9. Please evaluate the importance of your teeth. *(1-10, 10 being very important)* _____

10. How healthy are your teeth currently? (1-10, 10 being most healthy) _____

11. Is there anything about your teeth you would like to change? If so, explain.

12. Please rank the following in the order in which they would prevent you from having dental treatment.

(1-4, 1 being most important.)

*Fear of pain* _____ *Lack of concern* _____ *Cost of treatment* _____ *Missing work/school time* _____

13. Please briefly tell us about any NEGATIVE dental experiences you've had._____

# Medical History

**1. Who is your primary care physician?** _____ **Office phone number?**_____

**2. Have you ever been told by a doctor/dentist to take antibiotics before a dental procedure?..... □ Yes □No**

***If yes, what antibiotic did you normally premedicate with?(Amoxicillin, keflex, cleocin,etc)*** _____

**3. Have you had any serious illness, operation or been hospitalized in the past 2 years?..... □ Yes □ No**

**4. Are you actively taking blood thinners?.....□ Yes □ No**

**5. Have you ever taken bone loss prevention drugs?** *(Fosamax, Actonel, Boniva)* **..... □ Yes □ No**

***If yes, please list name/dosage:*** _____ ***How long have you been taking it?*** _____

**6. Are you *allergic* to any medication/substance? .....□ Yes □ No** If yes, please list: _____

**7. Please indicate which of the following you have had or have at present:**

**Heart attack**.....□ Yes □ No

**Heart disease**.....□ Yes □ No

**Heart murmur**.....□ Yes □ No

**High blood pressure**.....□ Yes □ No

**Low blood pressure**.....□ Yes □ No

**Mitral Valve Prolapse**.....□ Yes □ No

**Artificial valve/pacemaker**...□ Yes □No

**Anemia**.....□ Yes □ No

**Arthritis/rheumatism**.....□ Yes □ No

**Stroke**.....□ Yes □ No

**Artificial joints**.....□ Yes □ No

**Diabetes**.....□ Yes □ No

**Thyroid problems**.....□ Yes □ No

**Glaucoma**..... □ Yes □ No

**Tuberculosis**..... □ Yes □No

**Asthma**..... □ Yes □ No

**Latex sensitivity**..... □ Yes □ No

**Radiation therapy**..... □ Yes □ No

**Chemotherapy**..... □ Yes □ No

**Cancer**..... □ Yes □ No

**Crohn's disease**.....□ Yes □ No

**Hepatitis A B C** (circle).....□ Yes □No

**AIDS/HIV positive**.....□Yes □No

**Cold sores/fever blisters** ... □ Yes □No

**Excessive bleeding** .....□Yes □No

**Blood transfusion**.....□ Yes □No

**Liver disease**..... □ Yes □No

**Multiple sclerosis**.....□ Yes □ No

**Parkinson's disease**.....□ Yes □ No

**Epilepsy or seizures**.....□Yes □ No

8. Please list any condition/problem **NOT** listed above:_____

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***WOMEN ONLY:*** 9.Do you take birth control? □**Yes** □**No**

10. Are you pregnant or think you could be pregnant? □**Yes** □**No** If so, how many months? _____

11.Are you Nursing? □ **Yes** □ **No**

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I understand the above information is necessary to provide me with safe dental care. I have answered all to the best of my knowledge. Should more 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 this office of any change in my health or medication.

***Patient Signature*****_____** ***Date:*****_____**

***Dentist Signature:*** **_____** ***Date:*****_____**

# Medication List

* If you have a copy of your medication list, we are able to make a copy at the front desk. You may also email a copy to us at Frontdesk@sereneviewdental.com . Please notify us once completed. Thank you! *

Please list any medications (including over the counter meds, aspirin, vitamins, etc.) and dosage that you are currently taking:

| Medication | Dosage |
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