Patient Name_____ **DENTAL HISTORY**

Hello! Welcome to Serene View Dental.

Please complete both sides of this confidential form so that we may offer you the best possible care!

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

2. Date 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? _____

5. How often do you brush your teeth? _____ **How often do you floss your teeth?** _____

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

7. Do you have or have you ever had any of the following:

☐ 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

☐ hold foreign objects with teeth (pens, etc.)

☐ mouth breathe while awake or asleep

☐ have tired jaws, especially in the morning

☐ had orthodontic treatment (braces)

☐ oral surgery

☐ periodontal treatment

☐ your bite adjusted

☐ splint or mouth guard

☐ serious head or mouth injury

☐ fever blisters on lips or mouth

☐ 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 disorders

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

9. What level of health do you think your current health is in? (1-10, 10 being most healthy) _____

10. Is there anything about your teeth you would like to change? If so, please list. _____

11. Please rank the following options 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 _____

12. Please briefly tell us about any positive dental experiences you've had. _____

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

14. Is there anything you would like to know about our dental office? _____

Patient Name_____ **MEDICAL HISTORY**

1. Who is your primary care physician? _____

2. Have you ever been told by a doctor or another dentist that you need to take antibiotics before dental procedures? ☐ Yes ☐No

If yes, what antibiotic did you normally premedicate with? _____

3. Have there been any changes to your general health in the past year? ☐ Yes ☐ No _____

4. Have you had any serious illnesses, operations or been hospitalized in the past 5 years? ☐ Yes ☐ No_____

5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ☐ Yes ☐ No

If yes, please list name and dosage_____

6. Are you currently taking any medications? ☐ Yes ☐ No If yes, please list them on medications page.

7. Are you allergic to any medication or substance? ☐ Yes ☐ No If yes, please specify_____

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

Heart attack……☐ Yes ☐ No	Ulcers……☐ Yes ☐ No	Crohn's disease……☐ Yes ☐ No
Heart disease……☐ Yes ☐ No	Diabetes……☐ Yes ☐ No	Hepatitis A B C (circle)……☐ Yes ☐ No
Heart murmur……☐ Yes ☐ No	Thyroid problems……☐ Yes ☐ No	STD……☐Yes ☐ No
High blood pressure……☐ Yes ☐ No	Glaucoma……☐ Yes ☐ No	AIDS/HIV positive……☐Yes ☐ No
Low blood pressure……☐ Yes ☐ No	Tuberculosis……☐ Yes ☐ No	Cold sores/fever blisters ……☐ Yes ☐ No
Mitral Valve Prolapse……☐ Yes ☐ No	Asthma……☐ Yes ☐ No	Excessive bleeding ……☐Yes ☐ No
Artificial valve/pacemaker……☐ Yes ☐ No	Allergies/hay fever……☐ Yes ☐ No	Blood transfusion……☐ Yes ☐ No
Anemia……☐ Yes ☐ No	Sinus trouble……☐ Yes ☐ No	Liver disease……☐ Yes ☐ No
Arthritis/rheumatism……☐ Yes ☐ No	Latex sensitivity……☐ Yes ☐ No	Multiple sclerosis……☐ Yes ☐ No
Stroke……☐ Yes ☐ No	Radiation therapy……☐ Yes ☐ No	Parkinson's disease……☐ Yes ☐ No
Artificial joints……☐ Yes ☐ No	Chemotherapy……☐ Yes ☐ No	Epilepsy or seizures……☐Yes ☐ No
Fibromyalgia……☐ Yes ☐ No	Cancer……☐ Yes ☐ No	Psychological care……☐ Yes ☐ No

9. Do you have any disease, condition or problem not listed? ☐ Yes ☐ No If yes, please list: _____

_____

10. Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

11. **WOMEN ONLY:** Are you pregnant or think you could be pregnant? ☐ Yes ☐ No If so, how many months_____ Nursing? ☐ Yes ☐ No

12. **WOMEN ONLY:** Do you take birth control? ☐ Yes ☐ No

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/Guardian signature_____ Date_____

History Review

Dentist signature_____ Date_____

Patient Name_____ **MEDCATION LIST**

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

Medication	Dosage