Dental History

Patient Name

Medical Alert

Welcome! We'd like to provide you with the best possible care. Please fill out both sides of this form. All information is completely confidential.

What is the reason for your visit today? _____

Last Dental Visit: Last Dental Cleaning: Last Full Mouth X-Rays:

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address/Phone _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: _____

_____

ARE YOUR TEETH SENSITIVE TO:

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? Yes No
If yes, where?

DO YOU:

Clench or grind your teeth? Yes No
Bite your lips or cheeks regularly? Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws especially in the morning? Yes No
Snore or have any other sleeping disorders? Yes No
Smoke/chew tobacco, use other tobacco products? Yes No

HAVE YOU EVER HAD:

Orthodontic Treatment? Yes No
Oral Surgery? Yes No
Periodontal Treatment? Yes No
Your teeth ground or bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
If so, please describe, including cause:

HAVE YOU EXPERIENCED:

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
Headaches, neckaches, or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your smile? Yes No
Do you feel nervous about dental treatment? Yes No
Have you ever had an upsetting dental experience? Yes No

Have you ever been told to take a pre-medication prior to dental treatment?

Is there anything else about having dental treatment you'd like us to know?

DR. HATEM DDS

Medical History

Patient Name

Medical Alert

1. Physician's Name Phone
   Have you had any medical care within the past two years?---------- Y N
   Describe:
2. Have you taken any medication or drugs during the past two years?---------- Y N
3. Are you currently taking any medication, drugs, pills or hebal remedies, including aspirin? Y N
   If yes, please list name and dosage:
4. Have you ever taken prescription medications for weight loss (diet pills)?---------- Y N
   If yes, did you take any of the following? (circle) Fen-phen Pondimin Redux Other
5. Have you ever taken bone loss prevention drugs?---------- Y N
   If yes, did you take any of the following? (circle) Fosamax Actonel Boniva Other
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Y N
   If yes, please specify:
7. Have you been a patient in the hospital during the past five years?---------- Y N
8. Indicate which of the following you have had, or have at present. Circle yes or no to each.

Heart (surgery, disease, attack)	Y N	Ulcers	Y N	Hepatitis A B C (circle one)	Y N
Chest Pain	Y N	Diabetes	Y N	Venereal Disease	Y N
Congenital Heart Disease	Y N	Thyroid Problems	Y N	A.I.D.S./H.I.V. Positive	Y N
Heart Murmur	Y N	Glaucoma	Y N	Cold Sores/Fever Blisters	Y N
High/Low Blood Pressure	Y N	Contact Lenses	Y N	Blood Transfusion	Y N
Mitral Valve Prolapse	Y N	Emphysema	Y N	Hemophilia	Y N
Artificial Heart Valve/Pacemaker	Y N	Chronic Cough	Y N	Sickle Cell Disease	Y N
Rheumatic Fever	Y N	Tuberculosis	Y N	Bruise Easily	Y N
Arthritis/Rheumatism	Y N	Asthma	Y N	Liver Disease/Yellow Jaundice	Y N
Cortisone Medicine	Y N	Hay Fever/Allergy/Hives	Y N	Neurological Disorders	Y N
Swollen Ankles	Y N	Latex Sensitivity	Y N	Epilepsy or Seizures	Y N
Stroke	Y N	Sinus Trouble	Y N	Fainting or Dizzy Spells	Y N
Diet (special/restricted)	Y N	Radiation Therapy	Y N	Nervous/Anxious	Y N
Artificial Joints	Y N	Chemotherapy	Y N	Psychiatric/Psychological Care	Y N
Kidney Trouble	Y N	Tumors	Y N		Y N

9. Have you lost or gained more than 10 pounds in the past year? ---------- Y N
10. Do you have or have you had any disease, condition, or problem not listed?---------- Y N
    If yes, please describe:
11. WomeAre you pregnant or do you think you could be pregnant? Y ____Months N Nursing? Y N
12. Do you use birth control prescriptions?---------- Y N

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the question 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 any change in my health or medication.

Patient/Guardian Signature Date

Dentist Signature Date