Dental Health & Wellness Boston
For Your Health, Your Looks and Your Life

Medical/Dental History

Name:_____ Date of Birth:_____

Welcome! So that we may provide you with the best possible care please complete the questions below. All information is completely confidential.

What is the reason for your visit today?_____

Date of last dental visit _____ Last Dental Cleaning _____ Last Full Mouth X-Ray _____

What was done at your last dental visit? _____

Previous dentist's name _____ Telephone _____

Address_____ State _____

How often do you have dental examinations? _____

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

Have you ever used, or are you currently using a topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No If yes please describe: _____

Are any of 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 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 while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, etc.)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Sore or have other sleeping disorders?	Yes	No
Smoke/Chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head	Yes	No

If so, please describe _____

_____

Have you ever 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
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches, or shoulder aches?	Yes	No
Sore muscles? (neck, shoulders)	Yes	No

Are you happy with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Are you nervous about having dental treatment? Yes No

If so, what is your biggest concern?_____

Have you ever had an upsetting dental experience? Yes No

If yes please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

Physician's Name:_____Phone Number: ( )_____

Have you had any medical care within the past two years? Yes No

Describe_____

Have you taken any medication or drugs during the last two years? Yes No

Are you currently taking any medications, drugs or herbal remedies, including aspirin? Yes No

If yes, please list name and dosage_____

Have you ever take prescription medication for weight loss (diet pills)? Yes No

If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other

If yes to any of the above, did you have a medical exam for heart issues?..... Yes No

Have you ever taken a bone loss prevention drug such as Fosamax, Actonel, Boniva, or similar medication?..... Yes No

Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No

If yes please specify:_____

Have you been a patient in the hospital during the past five years? Yes No

If yes, for what?_____

Please indicate which of the following you have had or have at present. Please circle "yes" or "no" to each item.

Heart Surgery	Yes	No	Kidney Trouble	Yes	No	Hepatitis A B C	Yes	No
Heart Attack	Yes	No	Ulcers	Yes	No	Venereal Disease	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	A.I.D.S./H.I.V. Positive	Yes	No
Heart Disease	Yes	No	Thyroid Problems	Yes	No	Cold Sores	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No	Blood Transfusion	Yes	No
Low Blood Pressure	Yes	No	Contact Lenses	Yes	No	Hemophilia	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Sickle Cell Disease	Yes	No
Pacemaker	Yes	No	Chronic Cough	Yes	No	Bruise Easily	Yes	No
Artifical Heart Valve	Yes	No	Tuberculosis	Yes	No	Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Yellow Jaundice	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever/Allergy	Yes	No	Neurological Disorders	Yes	No
Cortisone Medication	Yes	No	Latex Allergy	Yes	No	Epilepsy or Seizures	Yes	No
Swollen Ankles	Yes	No	Sinus Trouble	Yes	No	Fainting/Dizzy Spells	Yes	No
Stroke	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Diet (restricted)	Yes	No	Chemotherapy	Yes	No	Psychiatric Care	Yes	No
Artificial Joints	Yes	No	Tumors	Yes	No			

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

Do you have, or have you have any disease, condition, or problem, not listed? Yes No

If yes, please list:_____

Women: Are you, or do you think you could be pregnant? .....Yes No If yes, how many months?_____

Are you nursing? Yes No Do you take birth control prescriptions Yes No

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

Patient/guardian signature:_____Date_____