MEDICAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

1	Physician's Name		Phone	
	Have you ever had any medical care in the past two years?		**YES**	**NO**
	Describe			
2	Have you ever taken any medication of drugs during the past two years?		**YES**	**NO**
	If yes, please list name of medication(s) & dosage(s)			
3	Are you currently taking any medications, drugs or herbal remedies, including regular dosages of aspirin?		**YES**	**NO**
	If yes, please list name of medication(s) & dosage(s)			
4	Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates?		**YES**	**NO**
	If yes, please list name of medication(s) & dosage(s)			
5	Are you aware of having an allergic **(or adverse)** reaction to any substance of medication?		**YES**	**NO**
	If yes, please specify			
6	Have you been a patient in the hospital during the past five years?		**YES**	**NO**

7 Indicate which of the following you have had or have at present:

Heart (Surgery, Disease, Attack)	**YES**	**NO**	Ulcers	**YES**	**NO**	Hepatitis (*circle*) *A B C*	**YES**	**NO**
Chest Pain	**YES**	**NO**	Diabetes	**YES**	**NO**	Venereal Disease	**YES**	**NO**
Congenital Heart Disease	**YES**	**NO**	Thyroid Problems	**YES**	**NO**	AIDS/HIV Positive	**YES**	**NO**
Heart Murmur	**YES**	**NO**	Glaucoma	**YES**	**NO**	Cold Sores/Fever Blisters	**YES**	**NO**
High/Low Blood Pressure	**YES**	**NO**	Contact Lenses	**YES**	**NO**	Blood Transfusion	**YES**	**NO**
Mitral Valve Prolapse	**YES**	**NO**	Emphysema	**YES**	**NO**	Hemophilia	**YES**	**NO**
Artificial Heart Valve/Pacemaker	**YES**	**NO**	Chronic Cough	**YES**	**NO**	Sickle Cell Disease	**YES**	**NO**
Rheumatic Fever	**YES**	**NO**	Tuberculosis	**YES**	**NO**	Bruise Easily	**YES**	**NO**
Arthritis/Rheumatism	**YES**	**NO**	Asthma	**YES**	**NO**	Liver Disease/Yellow Jaundice	**YES**	**NO**
Cortisone Medicine	**YES**	**NO**	Hay Fever/Allergy/Hives	**YES**	**NO**	Neurological Disorders	**YES**	**NO**
Swollen Ankles	**YES**	**NO**	Latex Sensitivity	**YES**	**NO**	Epilepsy or Seizures	**YES**	**NO**
Stroke	**YES**	**NO**	Sinus Trouble	**YES**	**NO**	Fainting or Dizzy Spells	**YES**	**NO**
Diet (Special/Restricted)	**YES**	**NO**	Radiation Therapy	**YES**	**NO**	Nervous/Anxious	**YES**	**NO**
Artificial Joints (Hip, Knees, etc.)	**YES**	**NO**	Chemotherapy	**YES**	**NO**	Psychiatric/Psychological Care	**YES**	**NO**
Kidney Trouble	**YES**	**NO**	Tumors	**YES**	**NO**			

8	Have you lost or gained more than 10 pounds in the past year?	**YES**	**NO**
9	Do you have or have you had any disease, condition or problem not listed?	**YES**	**NO**
	If yes, please specify		
10	**FOR WOMEN**: Are you pregnant or think you could be pregnant?	**YES**	**NO**
	Are you nursing?	**YES**	**NO**
	Do you use 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 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 Dr. Susan H. Mauk of any change in my health or medication.

Patient/Guardian Signature	Date

HISTORY REVIEW

Dr. Susan H. Mauk's signature	Date

DENTAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

1 What is the reason for your visit today?

2

Date of Last Dental Visit	Last Dental Cleaning	Last Full Mouth X-Rays

What was done at your last dental visit?

Previous Dentist's Name	Phone	
Address	State	ZIP

3

How often do you have dental examinations?	How often do you brush your teeth?	
How often do you floss your teeth?	Have you ever used or are currently using topical fluoride?	YES NO

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

4

Do you have any dental problems now?	YES NO

If yes, please describe

5

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 oders or bad tastes?	YES	NO
Do you frequently get cold sores, blisters or oral lesions?	YES	NO
Do your gums bleed or hurt?	YES	NO
Have your parents experiences gum disease/tooth loss?	YES	NO
Have you noticed any loose teeth or change in bite?	YES	NO
Does food tend to become caught between your teeth?	YES	NO

If yes, where?

Have you ever had:

Orthodontic treatment?	YES	NO
Oral surgery?	YES	NO
Periodontal treatment?	YES	NO
Your teeth ground or the bite adjusted?	YES	NO
A bite plate or mouth guard?	YES	NO
A serious injury to the mouth or head?	YES	NO

If yes, describe, including the cause

Have you experienced:

Clicking or popping of the jaw?	YES	NO
Pain? (joint, ear, side of the 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
Smoke/chew tobacco or use other tobacco products?	YES	NO

Do you:

Clench or grind your teeth while awake or asleep?	YES	NO
Bite your lips or cheeks regularly?	YES	NO
Hold objects with your teeth? (pens, fingernails, etc.)	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 or use other tobacco products?	YES	NO

Are you satisfied with your teeth's appearance? YES NO

Do you feel nervous about having dental treatment? YES NO

What are your biggest concerns?

Would you like to keep all of your teeth all of your life? YES NO

Have you ever had an upsetting dental experience? YES NO

If yes, please describe

6

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