COMMUNITY HEALTH
Centers of Oklahoma
Family Health & Dental Clinics
"A Mary Mahoney Grassroots Expansion"

DENTAL HISTORY

Welcome! Please complete both pages of this Dental / Medical History Form and bring with you so that we may provide you with the best possible Dental Care.

Patient Name: _____ Date of Birth: _____ Medical Alerts: _____

Drug Allergies: _____

Preferred Pharmacy: _____ Phone #: _____

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

What is the reason for your visit today? _____

Date of last dental visit? _____ Last dental cleaning: _____

What was done at your last dental visit? _____

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

What other dental aids do you use (waterpik, toothpicks, etc.?) _____

Do you use fluoride toothpaste? _____ Yes _____ No 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 taste? _____ 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 while awake or asleep? _____ Yes _____ No

Do you bite your lips or cheeks regularly? _____ Yes _____ No

Do you hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) _____ Yes _____ No

Do you mouth breathe while awake or asleep? _____ Yes _____ No

What is your biggest concern? _____

Have tired jaws, especially in the morning? _____ Yes _____ No

Snore or have any sleeping disorders? _____ Yes _____ No

If yes, please describe: _____

Smoke / chew tobacco or use other? _____ Yes _____ No

Drug and Alcohol use? _____ Yes _____ No

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

Have your parents experienced gum disease or tooth loss? _____ Yes _____ No

If yes, please describe, including cause: _____

_____

Have you ever experienced:

Clicking or popping of the jaw? _____ Yes _____ No

Pain (joint, ear, side or face)? _____ Yes _____ No

Difficulty in opening or closing your mouth _____ Yes _____ No

Difficulty in chewing on either side of the mouth? _____ Yes _____ No

Headaches, neck aches, or shoulder aches? _____ Yes _____ No

Are you satisfied with your teeth? _____ Yes _____ No

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

Are you nervous about having dental treatment? _____ Yes _____ No

If Yes, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience _____ Yes _____ No

If Yes, please describe: _____

_____

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

If Yes, please describe: _____

Please complete the second page of this form

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"Please tell us how did you hear about us?"

_____

_____

MEDICAL HISTORY

1. Physician's Name? _____ Phone #: _____

Have you had any medical care within the past two years (please include ER Visits)? _____ Yes _____ No

Describe: _____

2. Are you currently taking any medications, drugs, pills or herbal remedies, including regular dosages of aspirin?

_____ Yes _____ No If Yes, please list: _____

_____

3. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other similar drugs? _____ Yes _____ No

If Yes, please list: _____

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

If Yes, please specify: _____

5. Have you been in the hospital during the past five years? _____ Yes _____ No

If Yes, please specify: _____

6. ***Indicate which of the following you have had, or currently have. Check "Yes" or "No" for EACH item below:***

AIDS / HIV +	Yes No	Epilepsy or Seizures	Yes No	Neurological Disorder	Yes No
Arthritis / Rheumatism	Yes No	Fainting or Dizzy Spells	Yes No	Pacemaker	Yes No
Artificial Heart Valve	Yes No	Glaucoma	Yes No	Psychological / Psychiatric Care	Yes No
Artificial Joints (Hip, Knee, etc.)	Yes No	Hay Fever / Allergies / Hives	Yes No	Radiation Therapy	Yes No
Asthma	Yes No	HEART (Surgery / Disease / Attack)	Yes No	Sickle Cell Disease	Yes No
Blood Transfusion	Yes No	Hemophilia	Yes No	Sinus Trouble	Yes No
Bruise Easily	Yes No	Hepatitis	Yes No	Stroke	Yes No
Cancer	Yes No	If Yes ____ A ____ B ____ C		Stomach Problems	Yes No
Chemotherapy	Yes No	High / Low Blood Pressure	Yes No	Substance Abuse	Yes No
Chest Pain	Yes No	Kidney Trouble	Yes No	Swollen Ankles	Yes No
Chronic Cough	Yes No	Latex Sensitivity	Yes No	Thyroid Problems	Yes No
Cold Sore / Fever Blister	Yes No	Liver Disease / Jaundice	Yes No	Tuberculosis	Yes No
Congenital Heart Disease	Yes No	Lupus	Yes No	Tumors	Yes No
Cortisone Rx	Yes No	Mental Disorder	Yes No	Ulcers	Yes No
Diabetes	Yes No	Mitral Valve Prolapse	Yes No	Venereal Disease	Yes No
Emphysema	Yes No	Nervous / Anxious	Yes No		

7. Do you have or have you had any disease, condition, or problem not listed? _____ Yes _____ No

If Yes, please list: _____

8. Women: Are you pregnant or think you could be pregnant? _____ Yes _____ Months Nursing? _____ Yes _____ No

9. Do you use birth control prescriptions? _____ Yes _____ No

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should any further information be needed, you have my permission to ask the respective health care providers or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient / Guardian Signature: _____ Date: _____

For Office Use Only ---------- History Reviewed: _____ Yes _____ No

Dentist Signature: _____ Date: _____