



Willow Bend Dental

Dental & Health History

To provide you with the best possible care, please complete the dental & medical history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Date of Last Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

****HIPPA regulations requires you (the patient) to contact your previous Dentist to release your x-rays.****

How often do you have dental examinations? _____

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

What other dental aids do you use? (Sonicare, 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

Do you:

Notice any mouth odors or bad tastes? Yes No

Frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt?

Any gum disease in family members? Yes No

Tooth loss? Yes No

Have you noticed any loose teeth? Yes No

Have you noticed a change in bite? Yes No

Does food get caught in your teeth? Yes No

If yes, where? _____

Do you:

Clench or grind your teeth? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? Yes No

(i.e. pencils, pipe, pins, nails, fingernails)

Breathe through mouth? (awake or asleep) Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/chew tobacco? 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

If so please describe, including cause: _____

Have you noticed or experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing mouth? Yes No

Difficulty chewing on either side? Yes No

Headaches or shoulder aches? Yes No

Sore muscles? Yes No

Satisfied with your teeth's appearance? Yes No

Is keeping all of your teeth very important? Yes No

Do you feel nervous about treatment? Yes No

if so, what is your biggest concern? _____

Have you ever had an upsetting

dental experience? Yes No

If yes, describe: _____

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

If yes, please describe: _____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medication, drugs or pills now? Yes No
 If yes, please list name and dosage _____
4. Have you ever taken prescription medications for weight loss (diet pills)? Yes No
 If yes, did you take any of the following: Yes No Fen-Phen (fenfluramine-Phenpermine)
Yes No Pondimin (Fenfluramine)
Yes No Redux (Dexfenfluramine)
 If yes to any of the above, did you have a medical exam for heart disease? _____
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
 If yes, please list: _____
6. Have you been a patient in the hospital during the past five years? _____
7. Indicate which of the following you have had, or have at present. Check "yes" or "no" to each item.

Heart (surgery, disease, attack)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swollen Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies or Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diet (Special/Restriction)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints (hip,knee)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis A/B	<input type="checkbox"/> Yes <input type="checkbox"/> No	Veneral Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
A.I.D.S.	<input type="checkbox"/> Yes <input type="checkbox"/> No	H.I.V. Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nervous/Anxious	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric/Psychological	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Do you use more than two pillows to sleep? Yes No
9. Have you lost or gained more than 10 pounds in the past year? Yes No
10. Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list: _____

11. **Women: Pregnant?** Yes: Months? __ No **Nursing?** Yes No **Taking birth control pills?** 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 the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____