Dental History

So that we may provide you with the best possible care, please complete both sides of this medical and dental history form. All information is completely confidential.

What is the reason for your dental visit? _____

_____

Date of last dental visit _____ Last dental cleaning _____ Last X-Rays _____

What was done at your last dental visit? _____

Previous dentist's name _____

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

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

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

If yes, please explain _____

_____

1. Are any of your teeth sensitive to:
   - Hot or Cold ☐ Yes ☐ No
   - Sweets ☐ Yes ☐ No
   - Biting/Chewing ☐ Yes ☐ No
2. Have you ever noticed:
   - Bad Odor/Taste ☐ Yes ☐ No
   - Cold Sores/Oral Lesions ☐ Yes ☐ No
3. Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No
4. Have your noticed a change in your bite or loose teeth? ☐ Yes ☐ No
5. Does food tend to become caught between your teeth? ☐ Yes ☐ No

   (If yes, where?) _____
6. Do you:
   - Clench/Grind your Teeth ☐ Yes ☐ No
   - Bite your Lips or Cheeks ☐ Yes ☐ No
   - Hold Foreign Objects in your Teeth (Pencils, Fingernails, Pipe, Etc.) ☐ Yes ☐ No
   - Mouth Breathe Constantly ☐ Yes ☐ No
   - Smoke or Chew Tobacco ☐ Yes ☐ No
7. Do your gums bleed or hurt? ☐ Yes ☐ No
8. Have you ever had:
   - Orthodontic Treatment ☐ Yes ☐ No
   - Oral Surgery ☐ Yes ☐ No
   - Periodontal Treatment ☐ Yes ☐ No
   - Occlusal Adjustment ☐ Yes ☐ No
   - A Bite Plate/Mouth Guard ☐ Yes ☐ No
   - A Serious Head/Mouth Injury ☐ Yes ☐ No
9. Have you ever experienced:
   - Clicking/Popping of the Jaw ☐ Yes ☐ No
   - Pain in the Jaw or Face ☐ Yes ☐ No
   - Difficulty Opening or Closing Mouth ☐ Yes ☐ No
   - Sore Muscles in Neck or Shoulder ☐ Yes ☐ No
10. Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No
11. Would you like to keep all of your teeth all of your life? ☐ Yes ☐ No
12. Do you feel nervous about having dental treatment? ☐ Yes ☐ No

    (If so, what is your biggest concern?) _____

    _____

Please describe anything else about your dental history that you think is important. _____

_____

_____

2438 N Ponderosa Dr # C200, Camarillo, CA 93010 | (805) 987-6991

Medical History

Patient's last name | First | M.I.

1. Have you been under the care of a medical doctor during the last two years? ○ Yes ○ No

(If yes, for what?) | Date of last physical exam

Physician's name | Work phone

Current address | City | State | Zip Code

2. Have you taken any medication or drugs the past two years? ○ Yes ○ No

3. Are you taking any medication, drugs or pills now? ○ Yes ○ No

(If yes, please list the name(s) and dosage(s)):

4. Are you aware of having an allergic reaction to any medication or substance? ○ Yes ○ No

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

6. Do you now have or have you ever had any of the following? Please circle "Yes" or "No" to each item.

Pacemaker	Yes No	Bisphosphoriates (Fosomax, Bovina)	Yes No
Heart Disease	Yes No	Blood Disorder	Yes No
Shortness of Breath	Yes No	Thyroid Problems	Yes No
Chest Pain/Angina Pecoris	Yes No	Latex Sensitivity	Yes No
Heart Attack	Yes No	Allergies or Hives	Yes No
Rheumatic Fever/Heart Disease	Yes No	Venereal Disease	Yes No
Heart Murmur	Yes No	A.I.D.S.	Yes No
Heart Defect from Birth	Yes No	H.I.V. Positive	Yes No
Mitral Valve Prolapse	Yes No	Cold Sores/Fever Blisters	Yes No
High Blood Pressure/Hypertension	Yes No	Blood Transfusion	Yes No
Stroke	Yes No	Hemophilia	Yes No
Fainting Spells/Epilepsy	Yes No	Tumors	Yes No
Nervous Breakdown	Yes No	Cancer	Yes No
Lung Disease	Yes No	Radiation Therapy	Yes No
Asthma	Yes No	Chemotherapy	Yes No
Tuberculosis	Yes No	Neurologic Disorders	Yes No
Liver Disease	Yes No	Psychiatric Care	Yes No
Hepatitis	Yes No	Artifical Joints (hip, knee)	Yes No
Kidney Disease	Yes No	Restricted Diet	Yes No
Diabetes	Yes No	Arthritis	Yes No
Prolonged Bleeding after Injury	Yes No	Alzheimer's Disease	Yes No

7. **Women:** Are you pregnant? ○ Yes ○ No Nursing? ○ Yes ○ No Taking Birth Control Pills? ○ Yes ○ No

8. Is there anything of importance in your medical history that has not been asked?

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 any changes in my health or medication.

SIGN AT OUR OFFICE

Signature of responsible party | Relationship | Date

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Reset Form