NEIGHBORHOOD SMILES
Family Trusted Dental Care

Side 1

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Physician's Name: _____ Physician's Phone #: _____

Purpose of last physician visit: _____

Last physician visit: _____ General health? ❑ Poor ❑ Fair ❑ Good

HAVE YOU EVER HAD THE FOLLOWING:?

Circle:		Allergic reaction to:	Diagnosis Date
YES	NO	Penicillin or other antibiotics	_____
YES	NO	Aspirin or Ibuprofen	_____
YES	NO	Tetracycline	_____
YES	NO	Codeine or sedatives	_____
YES	NO	Latex	_____
YES	NO	Nut allergy	_____
YES	NO	Other medications_____	_____

Circle:		Condition:	Diagnosis Date
YES	NO	Antibiotics before dental treatment	_____
YES	NO	Artificial heart valve	_____
YES	NO	Heart (Surgery, Disease, Attack)	_____
YES	NO	Heart Pacemaker	_____
YES	NO	Congenital heart problems	_____
YES	NO	Heart murmur	_____
YES	NO	High blood pressure: Level/date:_____ _____	
YES	NO	Low blood pressure: Level/date:____ _____	
YES	NO	Stroke	
YES	NO	High cholesterol	_____
YES	NO	Anemia or other blood disorder	_____
YES	NO	Prolonged bleeding due to a cut	_____
YES	NO	Lung or breathing problems	_____
YES	NO	Tuberculosis	
YES	NO	Persistent cough or COPD	_____
YES	NO	Sinus problems	_____
YES	NO	Asthma	_____
YES	NO	Hives or skin rash	_____
YES	NO	Multiple Sclerosis	_____
YES	NO	Neuro-muscular disease	_____

Circle:		Condition:	Diagnosis Date
YES	NO	Osteoporosis or bone disorders	_____
YES	NO	Liver disease	_____
YES	NO	Hepatitis or jaundice	_____
YES	NO	Kidney disease	_____
YES	NO	Thyroid or parathyroid problems	_____
YES	NO	Ulcers	_____
YES	NO	Digestive disorders / acid reflux	_____
YES	NO	Diabetes (Insulin / Diet Controlled)	_____
YES	NO	Arthritis	_____
YES	NO	Artificial joints (hip, knee, etc.)	_____
YES	NO	Head or neck injuries	_____
YES	NO	Epilepsy, convulsions (seizures)	_____
YES	NO	Cold sores / fever blisters	_____
YES	NO	AIDS or HIV infection	_____
YES	NO	Sexually transmitted disease	_____
YES	NO	Steroid medication	_____
YES	NO	Cancer	_____
YES	NO	Chemotherapy	_____
YES	NO	Radiation therapy	_____
YES	NO	Emotional problems	_____
YES	NO	Psychiatric treatment	_____
YES	NO	Antidepressant medication	_____
YES	NO	Alcohol / drug dependency	_____
YES	NO	Glaucoma or eye problems	_____
YES	NO	Hearing problems	_____
YES	NO	Sleep Apnea	_____
YES	NO	Currently pregnant	_____
YES	NO	Are you a smoker ? _____Packs per day	
YES	NO	Do you use smokeless tobacco?	

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment: _____

_____

Please list ALL medications, herbal supplements and/or vitamins taken within the last two years, including osteoporosis medications, including Fosamax or Alendronate: _____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

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 of agency, who may release such information to you.

PATIENT SIGNATURE: _____ **DATE:** _____

DOCTOR'S REMARKS: _____

_____

_____

PLEASE COMPLETE BOTH SIDES OF FORM

NEIGHBORHOOD SMILES
Family Trusted Dental Care

Side 2

DENTAL HISTORY

Patient Name: _____ Last Dental Exam: _____

Last Dental Treatment _____ Last Dental X-Rays _____

Previous Dentist: _____ How long with this dentist: _____

How often are your teeth cleaned? _____

What is your immediate dental concern? _____

PLEASE ANSWER BY CIRCLING YES OR NO TO THE FOLLOWING:

YES NO Is there anything you would like to change about the look or feel of your teeth? If yes, please explain:

_____

_____

YES NO Dental fears or unfavorable experiences?

YES NO Problems with effectiveness or bad reactions to dental anesthetics?

YES NO Orthodontic treatment? (Date_____)

YES NO Periodontal (gum) treatment?

YES NO Gums that bleed when brushing or flossing?

YES NO Teeth that are sensitive to hot or cold?

YES NO Sore or painful teeth?

YES NO Difficulty swallowing?

YES NO Unpleasant taste or odor in your mouth?

YES NO Dry mouth, throat, and/or eyes?

YES NO Lost any teeth?

YES NO Jaw problems (temporomandibular joint)?

YES NO Difficulty in opening your mouth widely?

YES NO Stiff neck muscles?

YES NO Awaken with an awareness of your teeth or jaws?

YES NO Tension headaches?

YES NO Clench or grind your teeth?

YES NO Wear a bite splint, night guard, orthodontic retainer or sleep apnea appliance?

YES NO Do you have problems chewing bagels or gum?

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a removable partial or complete denture, please complete the following:

When did you receive your first partial or complete denture?

How long have you worn your present denture? _____

YES NO Has your present denture been relined?
When? _____

YES NO Is your present denture a problem?
Describe: _____

YES NO Are you satisfied with the appearance? _____

YES NO Are you satisfied with the comfort?

YES NO Are you satisfied with the chewing ability? _____

OFFICE USE ONLY:

DOCTOR'S REMARKS: _____

_____

Changes: _____ *Date:* _____ *Initials* _____

Changes: _____ *Date:* _____ *Initials* _____

Changes: _____ *Date:* _____ *Initials* _____

Changes: _____ *Date:* _____ *Initials* _____

PLEASE COMPLETE BOTH SIDES OF FORM