DENTAL EXCELLENCE OF

Hatfield

Medical/Dental History

Patient Name: _____
Last First Initial Nickname Date of Birth

DENTAL HISTORY

Previous Dentist: _____ Phone: _____

Address: _____

Date of last dental care: _____ Date of last x-rays: _____

When do you brush your teeth? ☐ Upon arising ☐ After eating any food ☐ After meals ☐ Before going to bed

Do you eat between meals? ☐ Y ☐ N
Do you eat sweets (candy, soda pop, chewing gum)? ☐ Y ☐ N
Have you had cavities? ☐ Y ☐ N
Have you had any teeth removed by extraction? ☐ Y ☐ N
Was an appliance placed? ☐ Y ☐ N
Have there been any injuries to the teeth (falls, chips, blows)? ☐ Y ☐ N
If yes, explain _____

Have you had periodontal treatment? ☐ Y ☐ N
Have you ever received local anesthetic? ☐ Y ☐ N
Do you floss or use mouth rinses? ☐ Y ☐ N
Have you had any previous problems with dental treatment? ☐ Y ☐ N
If yes, explain _____

Do you think there is anything wrong with your teeth? ☐ Y ☐ N
If yes, explain _____

MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Address: _____ Date of last visit: _____

Are you currently under a physician's care? ☐ Y ☐ N If yes, explain _____

Have you ever had any serious illnesses? ☐ Y ☐ N If yes, explain _____ Date _____

Have you ever had surgery? ☐ Y ☐ N If yes, explain _____ Date _____

Have you ever been hospitalized? ☐ Y ☐ N If yes, explain _____ Date _____

Please list any **MEDICATION(s)** you are currently taking:

_____

_____

Please list any **ALLERGIES** you have:

_____

_____

Have you had a history of any of the following?

- ☐ Acid reflux disease (GERD)
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune Disease
- ☐ Cancer
- ☐ Cardiac Transplant
- ☐ Chemical/Alcohol Dependency
- ☐ Congenital heart defects
- ☐ Diabetes If yes what age? _____
- ☐ Dizziness
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Eyesight problems
- ☐ Fainting Spells
- ☐ Frequent headaches
- ☐ Hayfever
- ☐ Hearing loss
- ☐ Heart murmur
- ☐ Heart trouble
- ☐ Hepatitis
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpetic Lesions/Cold Sores
- ☐ HIV/AIDS
- ☐ Immunosuppression
- ☐ Kidney trouble (dialysis)
- ☐ Liver problems
- ☐ MRSA
- ☐ Psychiatric disorders
- ☐ Organ Transplants
- ☐ Prosthetic Replacement
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Diseases
- ☐ Severe/ prolonged bleeding
- ☐ Speech impairment
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other _____

High Blood Pressure ___ Yes ___ No

Additional comments: _____

I certify that the above information is complete and accurate.

_____ _____ _____ _____
Date Patient Signature Date Dentist Signature