

# PATIENT DENTAL & MEDICAL HISTORY

## DENTAL HISTORY

Reason for today 's visit _____ Date of last dental cleaning _____ How often do you brush? _____ How often do you Floss? _____ Do you like your smile? _____ Are you interested in or like to know about cosmetic dental work such as Teeth whitening? _____ Invisalign (straighten teeth w/o braces)? _____ Veneers (enhance your smile In two visits) _____ Who may we thank for referral? _____	<p style="text-align: center;"><b>Circle "Yes" or "No" to indicate if you have or had any of the following :</b></p> Bad Breath                      Yes    No Bleeding Gums                    Yes    No Blisters on Lips or Mouth      Yes    No Broken Fillings                    Yes    No Burning Mouth                    Yes    No Cigarette or cigar smoking      Yes    No Clicking or popping jaw        Yes    No Dry mouth                          Yes    No Fingernail biting                 Yes    No Grinding teeth                    Yes    No	Jaw pain                              Yes    No Lip or cheek biting                Yes    No Loose teeth                          Yes    No Orthodontic treatment          Yes    No Pain around ear                    Yes    No Periodontal treatment          Yes    No Sensitivity to cold                Yes    No Sensitivity to heat                Yes    No Sensitivity to sweets             Yes    No Sensitivity to biting              Yes    No Sores or growths in your mouth    Yes    No TMJ problem                        Yes    No
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## MEDICAL HISTORY

Physician's Name: _____ Phone # _____ Date of last visit _____ Reason for last visit _____ <p><b>Please circle "Yes" or "No" to indicate you have or had any of the following:</b></p> AIDS                                Yes    No Anemia                                Yes    No Angina                                Yes    No Arthritis                              Yes    No Artificial heart valves            Yes    No Artificial joint                      Yes    No Asthma                                Yes    No Bleeding abnormally            Yes    No Blood disorder                    Yes    No Cancer                                Yes    No What area? _____ Radiation therapy? ____ When? ____ Chemotherapy? ____ When? ____ Circulation problem            Yes    No Congenital heart lesions        Yes    No Diabetes                              Yes    No	Emphysema                        Yes    No Epilepsy                              Yes    No Fainting or dizziness            Yes    No Frequent headaches             Yes    No Glaucoma                            Yes    No Heart murmur                      Yes    No Heart attack                        Yes    No Other heart problem? _____ Hepatitis                            Yes    No What type _____ Herpes                                Yes    No High/low blood pressure        Yes    No Kidney disease                    Yes    No Liver disease                      Yes    No Mitral valve prolapse            Yes    No Pacemaker                         Yes    No Psychiatric care                 Yes    No Respiratory disease             Yes    No Rheumatic fever                 Yes    No Sinus problem                    Yes    No Skin Problem                      Yes    No Special Diet                        Yes    No What type? _____	Stroke                                Yes    No Thyroid problem                  Yes    No Tonsillitis                         Yes    No Tuberculosis                      Yes    No Tumor or growth                 Yes    No What area? _____ What treatment done? _____ When? _____ Ulcer                                 Yes    No Unexplained weight loss        Yes    No Venereal disease                 Yes    No Women only: Are you pregnant?                Yes    No Due date _____ Are you nursing?                 Yes    No Taking birth control pill?      Yes    No <p><b>Please circle drug allergies:</b></p> Aspirin    Codeine    Vicodin Penicillin    Clindamycin    Erythromycin Tetracycline    Latex    Sulfa Local anesthetics    Valium Specify others _____
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**List any other medical condition** \_\_\_\_\_  
**List medications you're currently taking** \_\_\_\_\_

### PATIENT CONSENT FOR TREATMENT:

I have provided the information above to the best of my knowledge.  
 I authorize the dentists in Foster Dental Care to perform diagnostic procedures and treatments as may be necessary for proper care.  
 I have read, completed, and understood the contents on both sides of this form.

**Signature of Patient or Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_

(Office use only) Medical & Dental history reviewed by \_\_\_\_\_ Date \_\_\_\_\_