Dental History

WestlakeVillage DentalHealth

PATIENT NAME

What is the reason for your visit today? _____

_____

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

What was done at your last dental visit?_____

Previous Dentist's Name_____Telephone _____

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? (waterpik, electric toothbrush, etc.) _____

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

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot?.....❑ Yes ❑ No
Cold? .....❑ Yes ❑ No
Sweets? .....❑ Yes ❑ No
Biting or chewing? .....❑ Yes ❑ No
Do you frequently get cold sores?.....❑ Yes ❑ No
Do your gums bleed or hurt?.....❑ Yes ❑ No
Have you noticed any loose teeth or change in your bite?.....❑ Yes ❑ No
Does food tend to become caught in between your teeth? .....❑ Yes ❑ No
If yes, where?_____

Have you ever had:

Orthodontic treatment?.....❑ Yes ❑ No
Oral surgery? .....❑ Yes ❑ No
A bite plate or mouth guard?.....❑ Yes ❑ No
A serious injury to the mouth or head?.....❑ Yes ❑ No
If so, please describe, _____
_____

Do you:

Clench or grind your teeth? .....❑ Yes ❑ No
Bite your lips or cheek regulary?.....❑ Yes ❑ No
Hold foreign objects with your teeth? ..❑ Yes ❑ No
Mouth breathe while awake or asleep?...❑ Yes ❑ No
Have tired jaws especially in the morning? .....❑ Yes ❑ No
Snore or have any other sleeping disorder?.....❑ Yes ❑ No
Smoke or chew tobacco? .....❑ Yes ❑ No
Feel nervous about having dental treatment? .....❑ Yes ❑ No
If so, what is your biggest concern?
_____

Have you experienced:

Clicking or popping of the jaw? .....❑ Yes ❑ No
Pain? (Joint, ear, side of face)?.....❑ Yes ❑ No
Difficulty in chewing on either side of the mouth? .....❑ Yes ❑ No
Headaches, neckaches, shoulder aches? .....❑ Yes ❑ No

Have you ever had an upsetting dental experience? ❑ Yes ❑ No

If yes, please describe: _____

_____

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

If yes, please describe: _____

_____

(PLEASE COMPLETE OTHER SIDE)

Medical History

WestlakeVillage DentalHealth

PATIENT NAME	MEDICAL ALERT

1. Physician's Name_____ Phone ( )_____

2. Have you had any medical care within the past two years? ❑ Yes ❑ No
   Describe _____

3. Have you taken any medication or drugs during the past two years? ❑ Yes ❑ No

4. Have you ever taken antibiotics for an extended period of time? ❑ Yes ❑ No

5. Are you currently taking any medication, drugs, supplements or herbal remedies, including regular dosages of aspirin? ❑ Yes ❑ No
   If yes, please list name and dosage _____

6. Have you ever taken prescription medications for weight loss (diet pills)? ❑ Yes ❑ No
   If yes, did you take any of the following? ❑ Fen-Phen ❑ Pondimen ❑ Redux ❑ Other
   If yes to any of the above, did you have a medical exam for heart issues? ❑ Yes ❑ No

7. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ❑ Yes ❑ No

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

9. Indicate which of the following you have had, or have at present. Check "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No	Hepatitis A B C (circle)	❑ Yes ❑ No
Chest Pain	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Congenital Heart Disease	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No	A.I.D.S./H.I.V. Positive	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Cold Sores/Fever Blisters	❑ Yes ❑ No
High/Low Blood Pressure	❑ Yes ❑ No	Contact Lenses	❑ Yes ❑ No	Blood Transfusion	❑ Yes ❑ No
Mitral Valve Prolapse	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No
Artificial Heart Valve/Pacemaker	❑ Yes ❑ No	Chronic Cough	❑ Yes ❑ No	Sickle Cell Disease	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No	Bruise Easily	❑ Yes ❑ No
Arthritis/Rheumatism	❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Liver Disease/Yellow Jaundice	❑ Yes ❑ No
Cortisone Medicine	❑ Yes ❑ No	Hay Fever/Allergy/Hives	❑ Yes ❑ No	Neurological Disorders	❑ Yes ❑ No
Swollen Ankles	❑ Yes ❑ No	Latex Sensitivity	❑ Yes ❑ No	Epilepsy or Seizures	❑ Yes ❑ No
Stroke	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No	Fainting or Dizzy Spells	❑ Yes ❑ No
Diet (Special/Restricted)	❑ Yes ❑ No	Radiation Therapy	❑ Yes ❑ No	Nervous/Anxious	❑ Yes ❑ No
Artificial Joints (hip, knee, etc.)	❑ Yes ❑ No	Chemotherapy	❑ Yes ❑ No	Psychiatric/Psychological Care	❑ Yes ❑ No
Kidney Trouble	❑ Yes ❑ No	Tumors	❑ Yes ❑ No		

10. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ❑ Yes ❑ No
    If yes, please list:_____

11. Do you have or have you had any disease, condition, or problem not listed? ❑ Yes ❑ No
    If yes, please list:_____

12. Women: Are you pregnant or think you could be pregnant? ❑ Yes, ____Months ❑ No Nursing? ❑ Yes ❑ No

13. Do you use birth control prescriptions? ❑ 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 any change in my health or medication.

Patient/Parent/Guardian Signature_____ Date _____

Dentist Signature _____ Date _____