Life Enhancing Dentistry
407-205-9544

DENTAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

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

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_____

Address_____State_____Zip_____

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? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe:_____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have you parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become cause in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins,nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause_____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches? Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

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 Medical History page)

Life Enhancing Dentistry
407-205-9544

MEDICAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past 2 years?..... Yes No
   If yes, for what? _____
   Physician's Name_____Phone_____
   Address_____City_____State_____Zip_____
2. Have you taken any medication or drugs during the past two years?..... Yes No
3. Are you taking any medication, drugs or pills now?..... Yes No
   If yes, please list name and dosage_____
4. Are you aware of having an allergic (**or adverse reaction**) to any medication or substance?..... Yes No
   If yes, please list:_____
5. Have you been a patient in the hospital during the past five years?..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

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

7. Do you use more than two pillows to sleep?..... Yes No
8. Have you lost or gained more than 10 pounds in the past year?..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed?..... Yes No
   If yes, please list: _____
10. **Women.** Are you: **Pregnant?** Yes,__Months No **Nursing?** Yes No **Taking birth control pills?** 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/Guardian Signature _____Date_____

History Review

Dentist Signature_____Date_____