



DENTAL HISTORY

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.

Name _____ Date _____

Reason for seeing the Doctor today _____
 Date of last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____
 What was done at your last dental visit? _____
 Your previous Dentist's name _____ Address _____

How often do you see a dentist? _____ How often do you brush? _____ How often do you floss? _____
 Do you use dental aids? (toothpick, electric toothbrush, etc.) Yes No If yes, describe _____
 Do you have dental problems now? Yes No If yes, describe _____

<p>Are any of your teeth sensitive to:</p> <p>Hot or cold? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Sweets? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Biting or chewing? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Have you noticed any mouth odors or bad tastes? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do you frequently get cold sores, blisters or any other oral lesions? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do your gums hurt or bleed? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Have your parents experienced gum disease or tooth loss? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Have you noticed any loose teeth or change in your bite? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Does food become caught between your teeth? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, where? _____</p> <p>Do you:</p> <p>Clench or grind your teeth while awake or asleep? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Bite your lips or cheeks regularly? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Hold objects with your teeth? (Pencils, pins, nails, etc.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Mouth breathe while asleep or awake? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Have tired jaws, especially in the morning? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Smoke/chew tobacco? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Have you ever had:</p> <p>Orthodontic treatment? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Oral surgery? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Periodontal treatment? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Your teeth ground or the bite adjusted? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>A bite plate or mouth guard? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>A serious injury to the head or mouth? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, describe, including the cause _____</p> <p>Have you experienced:</p> <p>Clicking or popping of the jaw? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Pain? (Joint, ear, side of face) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Difficulty in opening/closing the mouth? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Difficulty chewing on either side of your mouth? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Head, neck or shoulder aches? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are you satisfied with the way your teeth look? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Would you like to keep all of your teeth all of your life? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do you feel nervous about having dental treatment? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, what is your biggest concern? _____</p> <hr/> <p>Have you ever had an upsetting dental experience? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, describe _____</p>
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Is there anything else about having dental treatment you would like us to know? _____

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what reason? _____

Physician's name _____ Address _____

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

Are you currently taking any medication, drugs or pills? Yes No If yes, list name and dosage below:

Name	Dosage	Name	Dosage	Name	Dosage
1. _____	_____	2. _____	_____	3. _____	_____
4. _____	_____	5. _____	_____	6. _____	_____

Are you aware of having an allergic or adverse reaction to any medication or substance? Yes No

If yes, describe _____

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

Please indicate which of the following you have had, or have at present. Check Y for Yes, N for No.

Heart Attack, Surgery or Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Ulcers	Y <input type="checkbox"/> N <input type="checkbox"/>	Hepatitis A (infectious) B (serum)	Y <input type="checkbox"/> N <input type="checkbox"/>
Chest Pain or Angina	Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>	Venereal Disease	Y <input type="checkbox"/> N <input type="checkbox"/>
Congenital Heart Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Thyroid Problems	Y <input type="checkbox"/> N <input type="checkbox"/>	A.I.D.S.	Y <input type="checkbox"/> N <input type="checkbox"/>
Heart Murmur	Y <input type="checkbox"/> N <input type="checkbox"/>	Glaucoma	Y <input type="checkbox"/> N <input type="checkbox"/>	H.I.V. Positive	Y <input type="checkbox"/> N <input type="checkbox"/>
High Blood Pressure	Y <input type="checkbox"/> N <input type="checkbox"/>	Auto Immune Deficiency	Y <input type="checkbox"/> N <input type="checkbox"/>	Cold Sores/Fever Blisters	Y <input type="checkbox"/> N <input type="checkbox"/>
Mitral Valve Prolapse	Y <input type="checkbox"/> N <input type="checkbox"/>	Emphysema	Y <input type="checkbox"/> N <input type="checkbox"/>	Blood Transfusion	Y <input type="checkbox"/> N <input type="checkbox"/>
Artificial Heart Valve	Y <input type="checkbox"/> N <input type="checkbox"/>	Chronic Cough	Y <input type="checkbox"/> N <input type="checkbox"/>	Hemophilia	Y <input type="checkbox"/> N <input type="checkbox"/>
Heart Pacemaker	Y <input type="checkbox"/> N <input type="checkbox"/>	Tuberculosis	Y <input type="checkbox"/> N <input type="checkbox"/>	Sickle Cell Disease	Y <input type="checkbox"/> N <input type="checkbox"/>
Rheumatic Fever	Y <input type="checkbox"/> N <input type="checkbox"/>	Asthma	Y <input type="checkbox"/> N <input type="checkbox"/>	Bruise Easily	Y <input type="checkbox"/> N <input type="checkbox"/>
Arthritis/Rheumatism	Y <input type="checkbox"/> N <input type="checkbox"/>	Hay Fever	Y <input type="checkbox"/> N <input type="checkbox"/>	Liver Disease or Jaundice	Y <input type="checkbox"/> N <input type="checkbox"/>
Cortisone Medicine	Y <input type="checkbox"/> N <input type="checkbox"/>	Latex Sensitivity	Y <input type="checkbox"/> N <input type="checkbox"/>	Anemia	Y <input type="checkbox"/> N <input type="checkbox"/>
Swollen Ankles	Y <input type="checkbox"/> N <input type="checkbox"/>	Allergies or Hives	Y <input type="checkbox"/> N <input type="checkbox"/>	Neurological Disorders	Y <input type="checkbox"/> N <input type="checkbox"/>
Stroke	Y <input type="checkbox"/> N <input type="checkbox"/>	Sinus Trouble	Y <input type="checkbox"/> N <input type="checkbox"/>	Epilepsy or Seizures	Y <input type="checkbox"/> N <input type="checkbox"/>
Diet (Special/Restricted)	Y <input type="checkbox"/> N <input type="checkbox"/>	Radiation Therapy	Y <input type="checkbox"/> N <input type="checkbox"/>	Fainting or Dizzy Spells	Y <input type="checkbox"/> N <input type="checkbox"/>
Artificial Joints (Hip, Knee, etc.)	Y <input type="checkbox"/> N <input type="checkbox"/>	Chemotherapy	Y <input type="checkbox"/> N <input type="checkbox"/>	Nervous/Anxious	Y <input type="checkbox"/> N <input type="checkbox"/>
Kidney or Bladder Trouble	Y <input type="checkbox"/> N <input type="checkbox"/>	Tumors	Y <input type="checkbox"/> N <input type="checkbox"/>	Psychiatric/Psychological Care	Y <input type="checkbox"/> N <input type="checkbox"/>

Do you have or have you had any disease, condition, or problem not listed above? Yes No

If yes, describe _____

Do you use more than two pillows to sleep? Yes No Have you lost or gained more than 10 pounds in the last year? Yes No

Women: Are you pregnant? Yes months _____ No Nursing? Yes No Taking birth control pills? Yes No

History Review (by Doctor):

I understand the information on both sides of this form 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. If further information is 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. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with patient. I further authorize and consent that Doctor choose and employ such assistance as deemed fit.

X _____
PATIENT SIGNATURE

DATE

X _____
PARENT/RESPONSIBLE PARTY SIGNATURE

DATE

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