

Medical History

Patient's name _____

1. Physician's name _____ Phone () _____

Have you had any medical care in the past two years? no yes

Please describe _____

2. Have you taken any drugs or medications during the past 2 years? no yes

3. Are you aware of having an allergic or adverse reaction to any medication? no yes

4. Are you currently taking any drugs, medication, pills, herbal remedies or regular dosages of aspirin? no yes

If your answer was yes, give name and dosage _____

5. Have you ever taken prescription weight loss medications (diet pills) no yes

If your answer was yes, did you take (please circle) Redux Fen-Phen Pondimen other

If you have taken any of the above, did you have a medical exam for heart issues? no yes

6. Have you ever taken bone loss prevention drugs such as Actonel, Boniva, Fosamax or other similar drugs?..... no yes

7. Have you been a hospital patient during the last five years? no yes

8. Which of the following do you have at present, or have you had – circle 'yes' or 'no' for each.

Heart (attack, surgery, disease).....	no	yes	Hepatitis A B C (circle one).....	no	yes	Emphysema.....	no	yes
Chest pain.....	no	yes	Venereal disease.....	no	yes	Chronic cough.....	no	yes
Heart murmur.....	no	yes	AIDS or HIV positive.....	no	yes	Tuberculosis.....	no	yes
Congenital heart disease.....	no	yes	Cold sores or fever blisters.....	no	yes	Asthma.....	no	yes
High or low blood pressure.....	no	yes	Blood transfusion.....	no	yes	Hay fever, allergy, hives.....	no	yes
Artificial heart valve, pacemaker....	no	yes	Sickle cell disease.....	no	yes	Latex sensitivity.....	no	yes
Mitral valve prolapse.....	no	yes	Hemophilia.....	no	yes	Radiation therapy.....	no	yes
Rheumatic fever.....	no	yes	Bruise easily.....	no	yes	Chemotherapy.....	no	yes
Cortisone medicine.....	no	yes	Liver disease or yellow jaundice...	no	yes	Tumors.....	no	yes
Arthritis or rheumatism.....	no	yes	Sinus trouble.....	no	yes	Neurological disorders.....	no	yes
Swollen ankles.....	no	yes	Ulcers.....	no	yes	Epilepsy or seizures.....	no	yes
Stroke.....	no	yes	Diabetes.....	no	yes	Dizzy spells or fainting.....	no	yes
Artificial joints (knee, hip, etc.)....	no	yes	Thyroid problems.....	no	yes	Nervous or anxious.....	no	yes
Diet – special or restricted.....	no	yes	Contact lenses.....	no	yes	Psychiatric or psychological care	no	yes
Kidney trouble.....	no	yes	Glaucoma.....	no	yes			

9. How much alcohol do you consume per week, if any _____

10. Do you sleep with 2 or more pillows? no yes

11. Have you gained or lost more than 10 pounds in the last year? no yes

12. Have you had or do you have now, any condition, disease or problem not listed? no yes

13. For women: Are you pregnant or think you may be pregnant? no yes _____months Nursing? no yes

14. Do you use birth control prescriptions?..... no yes

Please read and sign:

I understand the above information is necessary to provide me with dental care in a safe and an efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to contact my health care providers or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Signature of patient or patient's guardian _____ Date _____

Doctor review:

Dentist signature _____ Date _____



Dental History

Patient's name _____

Welcome to the dental office of Felines H. Tipton – *Family Dentistry with Love*

We ask that you complete both sides of this dental and medical history form so that we can provide you with the best possible dental care. If you have any questions about this form, please ask our dental assistants.

All information is completely confidential.

What is the purpose 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 _____ City/state/zip _____

Telephone _____

How often do you usually visit the dentist? _____

How often do you brush your teeth? _____

How often do you floss? _____

What other dental aids do you use, such as interplak, toothpicks, brush picks? _____

Do you have dental problems now? no yes

If you answered yes, please describe your problems _____

Are any of your teeth sensitive to...

hot or cold? no yes

sweets? no yes

biting or chewing? no yes

Have you noticed any mouth odors or bad tastes? no yes

Do you frequently get cold sores, fever blisters or other oral lesions? no yes

Do your gums hurt or bleed?..... no yes

Have your parents experienced tooth loss or gum disease? no yes

Have you noticed any loose teeth or change in your bite?..... no yes

Does food sometimes get caught in between your teeth? no yes
if so, where? _____

Do you...
clench or grind you teeth while awake or asleep? no yes

bite your lips or cheeks frequently? no yes

hold foreign objects like pencils, a pipe, pins,..... nails, fingernails with your teeth

snore or have any other sleep disorder? no yes

smoke, chew tobacco or use any tobacco products? ____ no yes

Have you ever had...

orthodontic treatment, braces? no yes

teeth extracted? no yes

periodontal treatment, root planning? no yes

your teeth ground or your bite adjusted? no yes

Have you had a serious injury to your mouth or head? no yes

If you answered yes, please describe and include cause:

Have you experienced...

clicking or popping of the jaw? no yes

pain in the joint, jaw, ear or side of face? no yes

difficulty in chewing on either side of the mouth? no yes

headaches, neck aches or shoulder aches..... no yes

sore muscles in you neck or shoulders?

Are you satisfied with the appearance of your teeth?..... no yes

Is it important to you to keep your teeth for the rest of your life?..... no yes

Do you feel nervous about having dental treatment? no yes

If so, what is your biggest concern? _____

Have you ever been told to take a pre-medication prior to dental treatment?..... no yes

Is there anything else you would like use to know about having dental treatment?..... no yes

If yes, please describe _____

(Please be sure to complete the other side)



Felines H. Tipton, DDS