Dental History

Patient Name:_____

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?_____
_____

▪ Previous Dentist_____Date of Last Exam/Cleaning_____X-rays_____

HOME CARE

How often do you brush?_____
Manual or electric brush
How often do you floss?_____
List other dental aids_____

FAMILY HISTORY

Oral Cancer:	□ Yes	□ No
Periodontal (gum) disease:	□ Yes	□ No
Excessive decay:	□ Yes	□ No
Premature tooth loss:	□ Yes	□ No

▪ Indicate, with a circle, which of the following conditions you have had or are currently experiencing.

Tooth sensitivity to hot or cold	Jaw pain or muscle tenderness
Sensitivity to biting or chewing	Clicking or popping of the jaw
Bad breath	Difficulty opening/closing your mouth
Cold sores	Difficulty chewing
Canker sores	Frequent headaches, neck or shoulder aches
Bleeding gums	Pain in and around your ear
Loose teeth	Chronic sinus problems
Changes in your bite	Orthodontic treatment (braces)
Food collection between teeth	Oral surgery/extraction of teeth
Clench or grind your teeth	Periodontal (gum) treatment
Bite lips and cheeks	Full or partial dentures
Biting fingernails	Bite splint or mouth guard
Mouth breathing	Injury to head, neck or mouth
Unusual reaction to local anesthesia	Dental Implants

▪ History of smoking or chewing tobacco use: □ Yes □ No
Are you interested in quitting? □ Yes □ No

▪ Do you feel nervous about having dental treatment? □ Yes □ No
If yes, please explain:_____
▪ Have you ever had an upsetting dental experience? □ Yes □ No
If yes, please explain:_____

▪ **Are you satisfied with the appearance of your teeth?** □ Yes □ No
If no, please explain:_____

Please complete other side

Examiner's Comments:

Kristin F. Nickodemus, DDS, PLC/Richard Han, DDS 1795 W. Stadium Blvd, Ann Arbor, MI 48103 734-769-4121 rh-kndds@comcast.net

Medical History

Physician:_____Office phone_____Date of last exam_____

• Are you currently being treated or have been treated for a medical condition in the past 12 months? □ Yes □ No
If yes, please explain_____

• Have you been hospitalized for any surgical operation or serious illness within the last 2 years? □ Yes □ No
If yes, please explain_____

• Are you currently taking any medication, drugs or pills (including regular doses of aspirin, vitamins, herbals and homeopathic meds)? □ Yes □ No
If yes, please list the names and dosages for your medications_____
_____

•Are you allergic to or have had an adverse reaction to any of the following? □ Yes □ No If yes, please circle all that apply

Aspirin	Penicillin	Local Anesthetic (eg. Novocaine)	Latex/Vinyl/Plastics
Ibuprofen	Erythromycin	Scopolamine	Metals
Codeine	Tetracycline	Sleeping Pills	Peanuts
Tylenol	Sulfa drugs/sulfites/sulfides	Nembutal, Seconal	Other medications_____
Valium	Other antibiotics	Milk Products	_____

• Have you ever taken prescription medication for weight loss (e.g., Fenphen, Redux)? □ Yes □ No

• Indicate, with a circle, which of the following conditions you have had or currently have.

Heart (Surgery, Disease, Attack)	Hepatitis (type_____)	Hemophilia
Chest pain	Liver disease/Jaundice	Bruise Easily
Heart Murmur/Mitral Valve Prolapse	Cancer	Lupus
Angina Pectoris	Radiation Treatments/Chemotherapy	Hearing Loss
High Blood Pressure	Venereal Disease (STD)	Canker/Cold Sores
Low Blood Pressure	A.I.D.S/H.I.V.	Eating Disorder
Heart Pacemaker	Epilepsy or Seizures	Chemical Dependency
Rheumatic Fever/Scarlet Fever	Fainting or Dizzy Spells	Smoking/Tobacco Use
Artificial Heart Valve	Anemia	_____Packs per day?
Congenital Heart Lesions	Frequent Hearburn/Reflux/Gerd	_____How many years?
Arthritis/Rheumatism	Recent Weight Loss	Jaw pain
Swollen ankles	Emotional or Nervous Disorders	Sinus Trouble
Stroke	Ulcers	Skin rash/Hives
Artificial Joints (hip, knee, etc.)	Diabetes	
Kidney Trouble	Emphysema	**WOMEN**
Thyroid Problems	Tuberculosis (TB)	Are you/could you be pregnant
Glaucoma	Asthma	Are you nursing
Contact Lenses	Hay Fever	Taking birth control pills

▪ If you have any disease, condition, or problem not listed above, please explain:_____
_____

I understand the above information is necessary to provide me 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 change in my health or medication.

_____ Date:_____
Signature of patient or guardian

Please complete other side

Examiner's Comments: