

Patient Name _____ Date _____

DENTAL HISTORY

*Welcome to Flower Dental! Please complete both sides of this Dental/Medical History form.
Each item is important for Dr. Flower to know. All information is completely confidential.*

What is the reason for your visit today? _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Dates: Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-Rays _____

What was done at your last dental visit? _____

Did any previous dentist recommend dental treatment that has not been performed? Yes No

If yes, what type of treatment was it? _____

Why was this treatment never performed? _____

How often do you:

Have dental examinations? _____ Brush your teeth? _____ Floss? _____

What dental aids do you use? (Sonicare, Rotodent, Interplak, toothpick, etc.) _____

Are your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or chewing? Yes No

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 your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or a change in your bite? Yes No

Does food tend to get caught between any of your teeth? Yes No

If yes, where? _____

Do you:

Clench/grind teeth while awake/asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth (pencils/pens, pipe, nails, fingernails)? Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke or chew tobacco? Yes No

Are you nervous about dental treatment? Yes No

Ever had an upsetting dental experience Yes No

If so, please describe _____

Have you ever had:

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal Treatment? Yes No

Your teeth ground or bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If yes, please describe, including cause

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty opening or closing your mouth? Yes No

Difficulty chewing anywhere in mouth? Yes No

Headaches, neck or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

TWO dental values that are most important to you?

___ Appearance, how good you look

___ Comfort, how comfortable you feel

___ Longevity, how long dental work lasts

___ Long-term cost effectiveness, least overall cost

ONE thing about your smile you would like to change most?

___ Color of teeth ___ Size/shape of teeth

___ Gaps ___ Too much gum shows

___ Tooth alignment ___ Nothing, I Love It

Other: _____

Would you like your smile analyzed? Yes No

If yes, is there a spouse or significant other you want to include in our discussion? Yes No

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

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MEDICAL HISTORY

Considerable evidence indicates that a person's physical health can impact their dental health and vice versa. Dr. Flower needs accurate information about your medical condition to provide the best possible dental care.

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 _____

2. Have you taken any medications, drugs or pills during the past 2 years? Yes No

If yes, please list the names (and if you know them, the dosages) _____

3. Are you currently taking any medications, drugs or pills? Yes No

If yes, please list the names (and if you know them, the dosages) _____

4. Do you have an allergy to any medication or substance? Any adverse reactions? Yes No

If yes, please list _____

5. Have you been a patient in a hospital during the past 5 years? Yes No

If yes, please describe _____

6. Do you currently have/have you ever had any of the following? Circle "Yes" or "No" for each item.

Tuberculosis	Yes	No	Steroid injections/treatment	Yes	No	Hepatitis A/infectious B/Serum	Yes	No
Asthma	Yes	No	Swollen Ankles	Yes	No	Venereal Disease	Yes	No
Hay fever	Yes	No	Stroke	Yes	No	AIDS	Yes	No
Hives	Yes	No	Diet: Special Restricted ...	Yes	No	HIV Positive	Yes	No
Allergies	Yes	No	Artificial Joints: Hip, Knee	Yes	No	Cold Sores / Fever Blisters ...	Yes	No
Sinus Trouble	Yes	No	Kidney Trouble	Yes	No	Blood Transfusion	Yes	No
Heart: disease, surgery .	Yes	No	Thyroid Problems	Yes	No	Hemophilia	Yes	No
Chest Pain	Yes	No	Ulcers	Yes	No	Sickle Cell Disease	Yes	No
Congenital Heart Disease	Yes	No	Diabetes	Yes	No	Bruise Easily	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Liver Disease	Yes	No
High Blood Pressure ...	Yes	No	Contact Lens	Yes	No	Yellow Jaundice	Yes	No
Mitral Valve Prolapse ..	Yes	No	Emphysema	Yes	No	Neurological Disorders	Yes	No
Artificial Heart Valve ..	Yes	No	Chronic Cough	Yes	No	Epilepsy, Seizures	Yes	No
Heart Pacemaker	Yes	No	Radiation Therapy	Yes	No	Fainting, Dizzy Spells	Yes	No
Rheumatic Fever	Yes	No	Chemotherapy	Yes	No	Nervous, Anxious	Yes	No
Arthritis/Rheumatism ..	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care .	Yes	No

7. Do you have sensitivity or allergic reaction to any of the following? Circle "Yes" or "No" for each item.

Aspirin	Yes	No	Latex gloves	Yes	No	Seasonal Allergens	Yes	No
E-Mycin Drugs	Yes	No	Lipro	Yes	No	Sulfa Drugs	Yes	No
Epinephrine	Yes	No	Naproxen	Yes	No	Tetracycline	Yes	No
Ibuprofen	Yes	No	Penicillin / amoxicillin	Yes	No	Valium	Yes	No

8. Do you use more than two pillows under your head to sleep? Yes No

9. Have you lost or gained more than 10 pounds in the past year? Yes No

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

11. WOMEN Are you: Taking birth control pills? Yes No
Pregnant or think you may be pregnant? . . . Yes, ___ months No
Nursing? Yes No

Verification of Dental and Medical History (Please initial each of the following items.)

- _____ I understand that Dr. Flower must be aware of my dental and medical history in order to provide me with safe, effective dental care.
- _____ I have answered all questions to the best of my knowledge. I will notify Dr. Flower of any change in my health or medication.
- _____ Dr. Flower has my permission to ask the respective health care provider or agency to release further information if needed.

signature of patient or guardian

date