

DENTAL HISTORY



STEVEN C. HOLLAR, DDS
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574-267-8466

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?

Have your 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 caught 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?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?

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?

Do you feel nervous about having dental treatment?	Yes	No
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If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience?

Have you ever had an upsetting dental experience?	Yes	No
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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 _____

MEDICAL HISTORY



STEVEN C. HOLLAR, DDS
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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 2 years?..... Yes No
3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin?..... Yes No
 If yes, please list name and dosage _____
4. Have you ever taken prescription medications for weight loss (diet pills)?..... Yes No
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance?..... Yes No
 If yes, please list: _____
6. Have you been a patient in the hospital during the past five years?..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surg., Disease, Attack) Yes No	Ulcers..... Yes No	Hepatitis A (infectious) B (serum).. Yes No
Chest Pain..... Yes No	Diabetes..... Yes No	Veneral Disease..... Yes No
Congenital Heart Disease..... Yes No	Thyroid Problems... Yes No	A.I.D.S..... Yes No
Heart Murmur..... Yes No	Glaucoma..... Yes No	H.I.V. Positive..... Yes No
High Blood Pressure..... Yes No	Contact Lenses..... Yes No	Cold Sore/Fever Blisters..... Yes No
Mitral Valve Prolapse..... Yes No	Emphysema..... Yes No	Blood Transfusion..... Yes No
Artificial Heart Valve..... Yes No	Chronic Cough..... Yes No	Hemophilia..... Yes No
Heart Pacemaker..... Yes No	Tuberculosis..... Yes No	Sickle Cell Disease..... Yes No
Rheumatic Fever..... Yes No	Asthma..... Yes No	Bruise Easily..... Yes No
Arthritis/Rheumatism..... Yes No	Hay Fever..... Yes No	Liver Disease..... Yes No
Cortisone Medicine..... Yes No	Latex Sensitivity..... Yes No	Yellow Jaundice..... Yes No
Swollen Ankles..... Yes No	Allergies or Hives... Yes No	Neurological Disorders..... Yes No
Stroke..... Yes No	Sinus Trouble..... Yes No	Epilepsy or Seizures..... Yes No
Diet (Special Restrictions) Yes No	Radiation Therapy.. Yes No	Fainting or Dizzy Spells..... Yes No
Artificial Joints (hip,knee,etc) .. Yes No	Chemotherapy..... Yes No	Nervous/Anxiety..... Yes No
Kidney Trouble..... Yes No	Tumors..... Yes No	Psychiatric/Psychological Care..... Yes No
8. Do you use more than 2 pillows to sleep?.....Yes No
9. Have you lost or gained more than 10 pounds in the past year?.....Yes No
10. Do you have or have you had any disease, condition, or problem not listed?.....Yes No
11. **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 change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature

Date