CARPINTERIA SMILES
DENTISTRY

Dental and Medical History Web Version: CarpinteriaSmiles.com

Thank you for taking the time to complete this medical and dental history form. The information provided here is confidential and guides us in making choices that provide for your best possible care.

Dental History

1. What is the primary reason you are seeking dental care at this time? *Click here to enter text.*
2. What was the approximate date of your last dental visit? *Click here to enter a date*.
3. What was the approximate date of your last dental cleaning? *Click here to enter a date*.
4. Have you had a full X-ray exam, (12-20 radiographs), in the past 3 years or less? Yes☐ No☐
5. If "YES" to #4, may we request the X-ray radiographs from your prior office? Yes☐ No☐
6. Previous Dental Office Name and/or Dentist's name: *Click here to enter text*.
7. Address and/or City in which prior office is located: *Click here to enter text*.
8. Telephone number or website of prior office: *Click here to enter text*.
9. How often do you normally have dental visits?
10. Your daily dental home care regimen consists of (select): Brush/Floss ☐ Brush Only☐ Brush/Other aid☐
11. **Do you have any dental problems now?** Yes☐ No☐
12. If "YES" to #11, please describe: *Click here to enter text.*
13. Do you require antibiotics for heart or prosthetic joint? Yes☐ No☐

Dental Details

Sensitive to hot /cold? .....Yes☐No☐

Sensitive to sweets? .....Yes☐No☐

Sensitive to biting pressure? .....Yes☐No☐

Odors or bad tastes? .....Yes☐No☐

Frequent cold sores, blisters, other sores? ..Yes☐No☐

Gums bleed or hurt? .....Yes☐No☐

Loose teeth or changes in bite? .....Yes☐No☐

Area where fibrous food always wedges? ...Yes☐No☐

Aware of clenching or grinding? .....Yes☐No☐

Regularly bite cheeks or lips? .....Yes☐No☐

Hold or bite fingernails, pencils, etc.? .....Yes☐No☐

Mouth breathe while awake or asleep? .....Yes☐No☐

Tired jaw muscles, especially in morning? ...Yes☐No☐

Snore or other sleep disorders? .....Yes☐No☐

Use any type of Tobacco products? .....Yes☐No☐

Had braces or orthodontics? .....Yes☐No☐

Had oral surgery? .....Yes☐No☐

Had periodontal treatment? .....Yes☐No☐

Had full mouth bite adjustments? .....Yes☐No☐

Wear a biteplate or nightguard? .....Yes☐No☐

Serious head or neck injury? .....Yes☐No☐

Clicking, pop, or pain in jaw joints? .....Yes☐No☐

Difficulty in opening and closing mouth? .....Yes☐No☐

Difficulty in chewing on either side? .....Yes☐No☐

Chronic Head, shoulder or neck aches? .....Yes☐No☐

Satisfied with your teeth's appearance? .....Yes☐No☐

Happy with your overall smile? .....Yes☐No☐

Committed to keeping all your teeth? .....Yes☐No☐

Nervous about dental care? .....Yes☐No☐

Had an upsetting experience in the past? ....Yes☐No☐

Open communication is the best tool for establishing a beneficial relationship. To that end, is there any topic we have not addressed that you would like to discuss? If so please mention it here and we can discuss it when next we meet:

Click here to enter text.

Medical History

1. Physician's Name *Click here to enter text.*

2. Physician's Phone *Click here to enter text.*

3. Any Medical Care in the past two years? Yes ☐ No☐

   If yes, please describe: *Click here to enter text.*

4. Have you taken medications or drugs in the past two years? Yes ☐ No ☐

   If yes, list name: *Click here to enter text.*

5. Check if you have used for osteoporosis or cancer therapy? Fosamax ☐ Actonel ☐ Boniva ☐

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

   If yes, please describe: *Click here to enter text.*

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

8. Indicate which of the following you have had or have at present:

Heart Surgery, Disease, or Attack Yes ☐ No ☐

Asthma Yes ☐ No ☐

Chest Pain Yes ☐ No ☐

Hay Fever/Allergies Yes ☐ No ☐

Congenital Heart Disease Yes ☐ No ☐

Latex Allergy Yes ☐ No ☐

Heart Murmur Yes ☐ No ☐

Sinus Problems Yes ☐ No ☐

High or Low Blood Pressure Yes ☐ No ☐

Radiation Therapy Yes ☐ No ☐

Mitral Valve Prolapse Yes ☐ No ☐

Chemotherapy Yes ☐ No ☐

Artificial Valve or Pacemaker Yes ☐ No ☐

Tumors Yes ☐ No ☐

Rheumatic Fever Yes ☐ No ☐

Hepatitis A ☐ B ☐ C ☐ D ☐ E ☐

Osteo or Rheumatoid Arthritis Yes ☐ No ☐

Venereal Disease Yes ☐ No ☐

Cortisone Medication Yes ☐ No ☐

AIDS or HIV Positive Yes ☐ No ☐

Swollen Ankles Yes ☐ No ☐

Cold Sores/Fever Blisters Yes ☐ No ☐

Stroke Yes ☐ No ☐

Blood Transfusions Yes ☐ No ☐

Special Medical Diet Yes ☐ No ☐

Hemophilia Yes ☐ No ☐

Artificial Joints, (knee, hip, etc.) Yes ☐ No ☐

Sickle Cell Disease Yes ☐ No ☐

Kidney Problems Yes ☐ No ☐

Bruise Easily Yes ☐ No ☐

Ulcers Yes ☐ No ☐

Liver Disease/Jaundice Yes ☐ No ☐

Diabetes Yes ☐ No ☐

Neurological Disorders Yes ☐ No ☐

Thryoid Problems Yes ☐ No ☐

Epilepsy or Seizures Yes ☐ No ☐

Glaucoma Yes ☐ No ☐

Fainting or Dizzy Spells Yes ☐ No ☐

Contact Lenses Yes ☐ No ☐

Nervous or Anxious Yes ☐ No ☐

Emphysema Yes ☐ No ☐

Psychological Care Yes ☐ No ☐

Chronic Cough Yes ☐ No ☐

Psychiatric Care Yes ☐ No ☐

Tuberculosis Yes ☐ No ☐

9. Do you have or have you had any disease or condition not listed? Yes ☐ No ☐

If yes, please describe: *Click here to enter text.*

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

11. WOMEN: Are you or could you be pregnant at this time? Yes ☐ No ☐

If yes, how many months along? *Click here to enter text.*

12. Do you use birth control prescriptions? Yes ☐ No ☐

I know that 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 any changes in my health or medication.

Parent or Guardian Signature_____Date_____

Dentists Signature_____Date_____