DENTAL HISTORY - Village Dental - David Archibald, D.M.D., Sc.D.

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 confidential. If you have any questions, please ask us for assistance. Thank you.

What is the reason for your visit today? _____
_____

When was your last dental visit? _____ Last dental x-rays? _____

Do you have any dental problems now? _____

I brush zero - once - twice - three - more times a day. (Circle one)
Do your use dental floss? Yes No
Do you use a water pik, rinses, mouth washes, or any other oral hygiene aids? Yes No
Which?_____

Are any of your teeth sensitive to:
- **Hot or cold? Yes No**
- **Sweets? Yes No**
- **Biting or chewing? Yes No**

Do your gums bleed or hurt? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Have you noticed any bad odors or tastes? Yes No
Does food tend to get caught in between your teeth? Yes No If yes, where?_____
Do you frequently get cold sores, cankers, blisters or any other lesions in your mouth or on your lips? Yes No
Do you:
- **Clench or grind your teeth while asleep or awake? Yes No**
- **Have pain, clicking or tightness in your jaws? Yes No**
- **Have difficulty in chewing? Yes No**
- **Smoke or use smokeless tobacco? Yes No**

Have you ever had:
- **Orthodontic therapy? Yes No**
- **Periodontal therapy? Yes No**
- **Serious injury to your mouth, face or head? Yes No**

Are you satisfied with the appearance of your teeth? Yes No If no, what concerns you? _____

Would you like to learn more about tooth whitening? Yes No
Have you ever had previous bad dental experiences? Yes No

Are you nervous about dental treatment? Yes No

Have you ever had a reaction to dental anesthetics? (Novocaine, lidocaine, etc.) Yes No

Is there anything else about having dental treatment that you would like us to know? _____
_____

(Please complete the other side)

MEDICAL HISTORY- Village Dental - David Archibald, D.M.D., Sc.D.

Are you presently under the care of a physician? Yes No

What is the condition for which you are being treated? _____

Physician's Name: _____ Telephone Number: _____
Street Address: _____ City, State and Zip Code: _____

Are you presently taking any medications? Yes No If yes, please give name and dosage_____

Have you been hospitalized in the past 5 years? Yes No

Are you allergic to any medications? Yes No If yes, please list: _____

Are you allergic to penicillin or any other antibiotics? Yes No

Are you allergic to local anesthetics? (lidocaine, novocaine, xylocaine) Yes No

Are you allergic to aspirin? Yes No

Are you allergic to latex (rubber gloves)? Yes No

Are you taking Bisphosphonates (Fosamax, Actonel, Skelid, Boniva, Didronel) for osteoporosis? Yes No

Are you taking blood thinners (coumadin. Plavix, Pradaxa, Ticlid, aspirin)? Yes No

Please indicate which of the following conditions you have or have had in the past. Circle "yes" or "no" for each item.

Rheumatic fever	**Yes No**	**Chemotherapy or radiation therapy**	**Yes No**
Heart disease	**Yes No**	**Epilepsy or seizures**	**Yes No**
Heart attack (myocardial infarction)	**Yes No**	**Fainting or dizzy spells**	**Yes No**
Heart murmur	**Yes No**	**Nervous or mental disorders**	**Yes No**
Hypertension (high blood pressure)	**Yes No**	**Bleeding disorders**	**Yes No**
Mitral valve prolapse	**Yes No**	**Sickle cell anemia**	**Yes No**
Artificial heart valve, hip joint or knee	**Yes No**	**Yellow jaundice or liver disease**	**Yes No**
Stroke	**Yes No**	**Thyroid disease**	**Yes No**
Lung disease	**Yes No**	**Arthritis**	**Yes No**
Tuberculosis (TB)	**Yes No**	**Steroid or hormone treatment**	**Yes No**
Asthma	**Yes No**	**Diabetes**	**Yes No**
Cigarette smoking	**Yes No**	**Venereal disease (syphilis, gonorrhea, herpes)**	**Yes No**
Swollen joints	**Yes No**	**Kidney disease**	**Yes No**
Surgery	**Yes No**	**Hepatitis**	**Yes No**
Blood transfusions	**Yes No**	**AIDS**	**Yes No**
Cancer or tumors	**Yes No**	**HIV positive**	**Yes No**

Have your ever used intravenous drugs such as heroin or cocaine? Yes No

Do you have any condition disease or problem not listed? Yes No

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Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

I understand 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, who may release such information. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature_____ Date_____

(Please complete the other side)