# Welcome to West Jordan Dental

**Please help us help you by completing this medical history form. Thank you**

**Name: _____**

1. Are you under medical treatment now? Y/N
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Y/N
   If yes, please explain _____.
3. Are you taking any medication(s) including non-prescription medicine? Y/N
   If yes, what medication(s) are you taking? _____

   _____.
4. Do you use tobacco? Y/N
5. Do you use controlled substances? Y/N
6. Have you ever taken Bisphosphonates? Y/N
7. Circle those you are allergic to or have had an allergic reaction to.
   Local Anesthetics (e.g. Novocaine) Penicillin or any other antibiotics
   Latex Rubber Other (please list) _____
8. Women Only:
   a. Are you pregnant or think you may be pregnant? Y/N
   b. Are you nursing? Y/N
   c. Are you taking oral contraceptives? Y/N
9. **Circle those you have or have had in the past**:

| | | | |
|---|---|---|---|
| High Blood Pressure | Stroke | Epilepsy | Emphysema |
| Low Blood Pressure | Kidney Disease | Seizures | Hay Fever |
| Heart Attack | Swollen Ankles | Convulsions | Respiratory Disease |
| Heart Disease | Liver Disease | Cancer | Asthma |
| Cardiac Pacemaker | Hepatitis | Ulcer | Allergies |
| Angina | STD'S | Stomach Troubles | Joint Replacement |
| Diabetes | AID'S or HIV | Thyroid Problem | None of the above |
| Glaucoma | Leukemia | Tuberculosis | |

Other_____

## PATIENT DENTAL HISTORY

Name of Previous Dentist and Location_____ Date of last Exam_____

| | Yes | No | |
|---|---|---|---|
| 1. | □ | □ | Do your gums bleed while brushing or flossing? |
| 2. | □ | □ | Are your teeth sensitive to hot or cold liquids/foods? |
| 3. | □ | □ | Are your teeth sensitive to sweet or sour liquids/foods? |
| 4. | □ | □ | Do you feel pain from any of your teeth? |
| 5. | □ | □ | Do you have any sores or lumps in or near your mouth? |
| 6. | □ | □ | Have you had any head, neck, or jaw injuries? |
| 7. | □ | □ | Do you frequently get cold sores or canker sores? |
| 8. | | | Have you have experienced |
| | □ | □ | Problems in your jaw? |
| | □ | □ | Clicking/ Popping? |
| | □ | □ | Pain in joint, ear, or side of face? |
| | □ | □ | Difficulty in opening or closing or chewing? |
| 9. | □ | □ | Do you have frequent headaches? |
| 10. | □ | □ | Do you clench or grind your teeth? |
| 11. | □ | □ | Do you bite your lips or cheeks frequently? |
| 12. | □ | □ | Have you ever had any difficult extractions in the past? |
| 13. | □ | □ | Have you ever had any prolonged bleeding following extractions? |
| 14. | □ | □ | Have you ever had any orthodontic treatment? |
| 15. | □ | □ | Have you ever been treated for Periodontal (Gum) Disease? |
| 16. | □ | □ | Do you wear dentures or partials? |
| 17. | □ | □ | Do you like your smile? |
| 18. | □ | □ | Is there anything you would like to change about your smile? Whiter? Straighter? |

_____

_____