Dove Dental Group Medical/Dental History

Patient Name:_____ D.O.B._____

MEDICAL HISTORY

Do you have or have you had any of the following? (Check all that apply)

- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma, Emphysema
- ☐ Autoimmune Disease
- ☐ Back Problems
- ☐ Blood Disease, Disorders
- ☐ Breathing Difficulty/Shortness of Breath
- ☐ Bruising
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cold Sores/Fever Blisters
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Glaucoma/Eye Disorders
- ☐ Headaches/Migraines
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A B or C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorder
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Persistent Cough
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Steroid/Cortisone
- ☐ Heart attack/Stroke
- ☐ Thyroid Disease
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Ulcer/Digestive Disorders
- ☐ Venereal Disease

Date of your last Dr. Appointment:_____ Are you under a Physician's care now? **Y N**
Have you ever been prescribed a dental premedication due to an existing medical condition? **Y N**

Allergies: ☐ None ☐ Penicillin ☐ Latex ☐ Metals ☐

Other_____

Please list **all** current medications including prescription, over-the-counter, vitamins, herbal and homeopathic remedies:_____

_____

Please describe any impending operations, recent injuries, hospitalizations (within the past 6 months) or other information the dentist should be aware of:_____

_____

(Women Only) Are you pregnant? **Y N** Due Date:_____ Are you nursing: **Y N**

DENTAL HISTORY

Do you have or have you had any of the following? (Check all that apply)

- ☐ Bleeding Gums
- ☐ Broken Fillings
- ☐ Chronic Bad Breath
- ☐ Decayed Teeth
- ☐ Food Impaction
- ☐ Grinding/Clenching
- ☐ Injury to Teeth or Jaw
- ☐ Loose Teeth
- ☐ Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Painful or Locking Jaw
- ☐ Sensitivity to Cold, Hot, Sweet, Chewing
- ☐ Sores, Growths, or Swelling in the Mouth

Date of your last dental visit?_____

What is the reason for your visit today?_____

Have past dental experiences been satisfactory?_____

How do you feel about the appearance of your teeth?_____

Are you interested in Invisalign or clear braces? **Y N**

SIGNATURE _____ **DATE**_____