

JACQUELINE L. SUBKA, D.D.S., APC

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Patient Name
Patient Account No.

DENTAL HISTORY

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? _____

Have you ever used or are currently using topical fluoride? Yes No

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? Yes No

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

Snore or have any other sleeping disorders? Yes No

Smoke/chew tobacco or use other tobacco products? 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? 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? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, describe _____

Have you ever been told to take pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

(Please complete other side)

MEDICAL HISTORY

Patient Name _____
Patient Account No. _____

Medical Alert _____

1. Physician's Name _____ Phone _____
 Have you had any medical care within the past two years? Yes No
 Describe _____
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medication, drugs, pills or herbal remedies, 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
 If yes, did you take any of the following? (circle if yes) Fen-Phen Pondimin Redux Other
 If yes to any of the above, did you have a medical exam for heart issues? Yes No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs Yes No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No
 If yes, please specify _____
7. Have you been a patient in the hospital during the past five years? Yes No
8. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack) ... Yes No	Ulcers Yes No	Hepatitis A B C (circle) .. Yes No
Chest Pain Yes No	Diabetes Yes No	Venereal Disease Yes No
Congenital Heart Disease Yes No	Thyroid Problems Yes No	A.I.D.S./H.I.V. Positive Yes No
Heart Murmur Yes No	Glaucoma Yes No	Cold Sores/Fever Blisters Yes No
High/Low Blood Pressure Yes No	Contact Lenses Yes No	Blood Transfusion Yes No
Mitral Valve Prolapse Yes No	Emphysema Yes No	Hemophilia Yes No
Artificial Heart Valve/Pacemaker ... Yes No	Chronic Cough Yes No	Sickle Cell Disease Yes No
Rheumatic Fever Yes No	Tuberculosis Yes No	Bruise Easily Yes No
Arthritis/Rheumatism Yes No	Asthma Yes No	Liver Disease/Yellow Jaundice Yes No
Cortisone Medicine Yes No	Hay Fever/Allergy/Hives Yes No	Neurological Disorders Yes No
Swollen Ankles Yes No	Latex Sensitivity Yes No	Epilepsy or Seizures Yes No
Stroke Yes No	Sinus Trouble Yes No	Fainting or Dizzy Spells Yes No
Diet (Special/Restricted) Yes No	Radiation Therapy Yes No	Nervous/Anxious Yes No
Artificial Joints (hip, knee, etc.) ... Yes No	Chemotherapy Yes No	Psychiatric/Psychological Care Yes No
Kidney Trouble Yes No	Tumors 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
 If yes, please list: _____
11. **Women:** Are you pregnant or think you could be pregnant? Yes _____ Months No **Nursing?** Yes No
12. Do you use birth control prescriptions? 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 any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____