MEDICAL HISTORY

Mark A. Moats, D.M.D

Patient Name_____Date of Birth_____

1. Have you been under the care of a medical doctor during the past two years?.....Yes No
2. Have you taken any medications or drugs during the past two years?.....Yes No
3. a)Are you taking any medications, drugs or pills now? .....Yes No
   If yes, Please list name and dosage_____

   _____

   b)Have you ever taken prescription medications for Osteoporosis(Bisphosphonate) ……..Yes No
4. Have you ever taken prescription medications for weight loss (diet pills)…….....Yes No
   If yes, did you take any of the following: Yes No Fen-Phen (Fenfluramine-Phenpermine)
   Yes No Pondimen (Fenfluramine)
   Yes No Redux (Dexfenfluamine)
5. Are you aware of having an allergic (or adverse reaction) to any medication or substance……..Yes No
   If yes, please list_____
6. Have you been a patient in the hospital during the past five years?.....Yes No
7. 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(infectious) B serum	Yes	No
Chest Pain	Yes	No	**Diabetes**	Yes	No	**Venereal Disease**	Yes	No
Congenital Heart Disease	Yes	No	**Thyroid**	Yes	No	**A.I.D.S.**	Yes	No
Heart Murmur	Yes	No	**Glaucoma**	Yes	No	**H.I.V. Positive**	Yes	No
Mitral Valve Prolapse	Yes	No	**Emphysema**	Yes	No	**Blood Transfusion**	Yes	No
Artificial Heart Valve	Yes	No	**Chronic Cough**	Yes	No	**Hemophilia**	Yes	No
Heart Pacemaker	Yes	No	**Tuberculosis**	Yes	No	**Sickle Cell Disease**	Yes	No
Rheumatic Fever	Yes	No	**Asthma**	Yes	No	**Bruise Easily**	Yes	No
Arthritis/Rheumatism	Yes	No	**Hay Fever**	Yes	No	**Liver Disease**	Yes	No
Cortisone Medicine	Yes	No	**Latex Sensitivity**	Yes	No	**Yellow Jaundice**	Yes	No
Swollen Ankles	Yes	No	**Allergies Hives**	Yes	No	**Neurological Disorders**	Yes	No
Stroke	Yes	No	**Sinus Trouble**	Yes	No	**Epilepsy or Seizures**	Yes	No
Diet (special/restricted)	Yes	No	**Radiation Therapy**	Yes	No	**Fainting or Dizzy Spells**	Yes	No
Artificial Joints (hip, knee, etc)	Yes	No	**Chemotherapy**	Yes	No	**Nervous/Anxious**	Yes	No
Kidney Trouble	Yes	No	**Tumors**	Yes	No	**Psychiatric/Psychological Care**	Yes	No
High Blood Pressure	Yes	No	**Contact Lenses**	Yes	No	**Cold Sores/Fever Blisters**	Yes	No

8. Do you use more than two pillows to sleep?.....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
11. **Women Only** Are you: **Pregnant?** Yes ____months **Nursing?** Yes No **Taking Birth Control** 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 change in my health or medication.

Patient/Guardian Signature_____Date_____

History Review

Dentist Signature_____

DENTAL HISTORY

Mark A. Moats, D.M.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 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 Name _____Address _____Phone #_____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss _____
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	**Have you ever had orthodontic treatment**	Yes	No
Are any of your teeth sensitive to sweets	Yes	No	**Have you ever had oral surgery**	Yes	No
Are any of your teeth sensitive to biting or chewing	Yes	No	**Have you ever had Periodontal treatment**	Yes	No
Have you noticed any mouth odors or bad tastes	Yes	No	**Have you ever had your bite adjusted**	Yes	No
Do you frequently get cold sores, blisters or lesions	Yes	No	**Have you ever had a bite plate or mouth guard**	Yes	No
Do your gums bleed or hurt	Yes	No	**Have you ever had a serious mouth/head injury If Yes please describe:_____ _____**	Yes	No
Have your parents experienced gum disease or tooth loss	Yes	No	**Have you experienced clicking or popping of jaw**	Yes	No
Have you noticed any loose teeth or change in bite	Yes	No	**Have you experienced Pain (joint, ear, face)**	Yes	No
Does food tend to get caught in between your teeth If yes, where:	Yes	No	**Have you experienced difficulty opening/closing**	Yes	No
Do you Clench or grind your teeth while awake or asleep	Yes	No	**Have you experienced Headaches, neck aches or shoulder aches**	Yes	No
Do you hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No	**Have you experienced Sore muscles (neck, shoulders**	Yes	No
Do you bite your lips or cheeks regularly	Yes	No	**Are you satisfied with your teeth's appearance?**	Yes	No
Do you Mouth breathe while awake or asleep	Yes	No	**Would you like to keep all teeth for all your life**	Yes	No
Do you have tired jaws, especially in the morning	Yes	No	**Do you feel nervous about having dental treatment? If yes, what's your biggest concern?**	Yes	No
Do you Smoke/Chew tobacco	Yes	No	**Have you ever had an upsetting dental experience? If yes, Please describe:**	Yes	No

Is there anything else about having dental treatment that you would like us to know?
If yes, please describe _____
_____