Bluejay Family Dentistry
Dental History

Name: _____ Date of Birth: _____

Welcome! Please complete both sides of this dental & medical history form so that we may provide you with the best possible dental care.

All information is completely confidential.

What is the reason for your visit today? _____

Date of last dental visit _____ Date of last dental cleaning _____

Date of last full mouth x-rays _____ 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 you currently using topical fluoride? ☐ Yes ☐ No

What other dental aids do you use (Softpick, Waterpik, etc.)? _____

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: _____

Are any of your teeth sensitive?..... ☐ 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 you noticed any loose teeth?..... ☐ Yes ☐ No
Does food tend to become caught in between your teeth?..... ☐ Yes ☐ No

Do you:
Clench or grind your teeth?..... ☐ 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
Use any tobacco products?..... ☐ Yes ☐ No

If yes, please describe:_____

Have you ever had:
Orthodontic treatment?..... ☐ Yes ☐ No
Periodontal (gum) treatment?..... ☐ Yes ☐ No
A bite plate or mouth guard?..... ☐ Yes ☐ No
A serious injury to the mouth or head?..... ☐ Yes ☐ No

If yes, please describe:_____

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?..... ☐ Yes ☐ No

Are you satisfied with your teeth's appearance? ☐ Yes ☐ No
Do you feel nervous about dental treatment?.... ☐ Yes ☐ No
Have you ever had an upsetting dental experience?..... ☐ Yes ☐ No

If yes, please describe: _____

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

Is there anything else about your dental history or treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe: _____

PLEASE SEE OTHER SIDE →

Bluejay Family Dentistry
Medical History

1. Are you under a physician's care now?.....☐ Yes ☐ No

If yes, please list the name and clinic of your physician:_____

2. Please describe any hospitalizations or major operations you have had: _____

3. Please list any medications, supplements or herbal remedies you are taking: _____

_____

4. Are you taking any **blood thinners**? (Coumadin, Warfarin, Plavix, Aspirin, Vitamin E, Gingko, Fish oil, or others?.....☐ Yes ☐ No

If yes, please list: _____

5. Have you ever taken any **bone density medications** or **bisphosphonates** such as Fosamax, Boniva, Actonel, Zometa, Aredia, Xgeva, Prolia, Reclast, or others?.....☐Yes ☐ No

If yes, please list: _____

6. Do you use tobacco? (please list): _____

7. Do you use controlled substances? (please list): _____

8. **Women**: are you pregnant? ☐ Yes ☐ No……Nursing? ☐ Yes ☐ No……..Taking oral contraceptives? ☐ Yes ☐ No

9. Are you allergic to any of the following:
☐ Penicillin/Amoxicillin ☐ Other Antibiotics ☐ Local Anesthetics ☐ Latex ☐ Metal
☐ Other (please list): _____

Do you have, or have you had, any of the following? Please circle any that apply:

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Angina
Anemia
Arthritis/Rheumatism
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Breathing Problems
Cancer
Chest Pains
Chemotherapy
Cold Sores
Congenital Heart Disorder
COPD
Diabetes Type 1
Diabetes Type 2
Drug Addiction
Epilepsy or Seizures
Excessive Bleeding
Fainting Spells/Dizziness
Frequent Cough
Glaucoma
Heart Attack
Heart Disease
Heart Failure
Heart Murmur
Heart Pacemaker
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Irregular Heartbeat
Kidney Disease
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Neurological Disorders
Osteoporosis
Pain in Jaw Joints
Parkinson's Disease
Psychiatric Care
Radiation Treatments
Renal Dialysis
Rheumatic Fever
Sexually Transmitted Disease
Sinus Trouble
Stomach Ulcers/GERD
Thyroid Disease
Tuberculosis

Do you have or have you had any disease, condition, or problem not listed?.....☐Yes ☐ No

If yes, please describe: _____

Patient or Legal Guardian Signature _____ **Date** _____

Printed Name of Legal Guardian _____