LeMars Dental Center
1311 Hawkeye Ave SW
LeMars, IA 51031
712.546.5183

Dental History

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.

Patient Name		Date of Birth	
What is the reason for your visit today?			
Date of Last Dental Visit	Last Dental Cleaning	Last Full-Mouth X-rays	How often do you have dental examinations?
Previous Dentist's Name	Address	City/State/Zip	Phone #
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? 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
Have you ever had Periodontal Treatment/Gum Disease?	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, etc.)	Yes	No
Smoke or chew tobacco?	Yes	No

Sleep:

Do you mouth breathe while awake or asleep?	Yes	No
Do you wake up refreshed?	Yes	No
Do you snore?	Yes	No
Have you been diagnosed with sleep apnea?	Yes	No
Do you wear a CPAP for sleep?	Yes	No

Have you ever had:

Orthodontic treatment (braces)?	Yes	No
Oral Surgery (wisdom teeth removed)?	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:

Mouth guard or bite adjusted	Yes	No
Clicking or popping of the jaw?	Yes	No
Pain (joint, ear, side of the face)?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Do you have tired jaws, especially in the morning?	Yes	No
Headaches, neck aches, or shoulder aches?	Yes	No
Sore muscles (neck, shoulders, face)?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Are you satisfied with your teeth's appearance?	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? If so, please describe:	Yes	No
Is there anything else about having dental treatment that you would like us to know? If yes, please describe.		

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Medical History

Patient Name			Date of Birth
Have you been under the care of a medical doctor during the past two years?			Yes No
If yes, for what?			
Physician's Name	Address	City/State/Zip	Phone #
Have you taken any medication or drugs during the past two years?			Yes No
Are you taking any medication, drugs or pills now?			Yes No
If yes, Please list:			
Have you been a patient in the hospital during the past five years			Yes No
Are you allergic to any medications?			Yes No
If yes, Please list:			

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 (infections) B (serum)	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.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	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 or 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

Do you use more than two pillows to sleep? Yes No
Have you lost or gained more than 10 pounds in the past year? Yes No
Do you have or have you had any disease, condition or problem not listed? Yes No
If yes, please list:

WOMEN ONLY:
Are you pregnant? If yes, how many months? _____ Yes No
Nursing? Yes No
Do you use medical contraceptives (i.e. birth control pills, patch, shots, contraceptive implant)? Yes No
If so, What? ____

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: __________________________ *Relationship:* ___________________ *Date:* ________

History Review:

Doctor Signature: ____ *Date:* ________________________________