Dental Oasis
Family Dentistry

925-846-4491 925-846-1422
office@dentaloasispleasanton.com

DENTAL & MEDICAL HEALTH HISTORY

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: _____ **PATIENT FIRST NAME:** _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No		Yes	No
Bad breath	☐	☐	Head, neck, jaw pain, or aches	☐	☐
Blisters on lips or mouth	☐	☐	Lip or cheek biting	☐	☐
Burning sensation on tongue	☐	☐	Loose teeth or broken fillings	☐	☐
Chew on one side of mouth	☐	☐	Mouth breathing	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐	Orthodontic treatment	☐	☐
Smokeless tobacco	☐	☐	Nitrous Oxide	☐	☐
Dry mouth	☐	☐	Periodontal treatment	☐	☐
Food collection between teeth	☐	☐	Sensitivity to pressure or irritants	☐	☐
Clench or grind teeth	☐	☐	(cold, heat, sweets)		
Growths or sore spots in your mouth	☐	☐	How often do you floss? _____		
Gums swollen, tender or bleeding	☐	☐	How often do you brush? _____		

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ☐ Yes ☐ No

If Yes, please explain _____

Have you ever had trouble from previous dental care? ☐ Yes ☐ No

If Yes, please explain _____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____ Blood Pressure _____

Have you had any serious illnesses or operations ☐ Yes ☐ No

If yes, please describe _____

Have you ever had a blood transfusion ☐ Yes ☐ No If yes, give approximate dates _____

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MEDICAL HISTORY

(Women) Are you pregnant? ☐ Yes ☐ No Due date _____ Nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Please check if you have/had:	Yes	No
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Required Hospitalization	☐	☐
Have you used steroids	☐	☐
Date of last episode ____	☐	☐
Bleeding abnormally with operations or surgery	☐	☐
Blood disease, clotting disorders	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type _____	☐	☐

	Yes	No
Herpes	☐	☐
High blood pressure	☐	☐
Any immune deficiency	☐	☐
Jaundice	☐	☐
Kidney disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Pacemaker	☐	☐
Radiation treatments	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Sickle cell anemia	☐	☐
Skin rash	☐	☐
Slow healing wounds	☐	☐
Stroke	☐	☐
Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐
Tonsilitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐

MEDICAL HISTORY

Please check if you have/had:	Yes	No
Weight loss, unexplained	☐	☐
Do you wear contact lenses?	☐	☐
Do you consume alcoholic beverages?	☐	☐
Are you currently under the care of a Physician?	☐	☐
Are you allergic/sensitive to Latex?	☐	☐
Allergic to Penicillin, Aspirin, or other drugs?	☐	☐

If Yes, please specify _____

List any medications that you are taking: _____

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Reviewed by: _____ Date _____