Christopher T King, DDS, PC

4605 HAYGOOD ROAD | VIRGINIA BCH VA, 23455 | (757) 464-6228

Patient Name:____ **Date of Birth:** ____________________

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form completely. 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 ______________________________ Telephone________________________

Address ____

How often do you have dental examinations?______________________________________

How often do you brush your teeth? __________________ How often do you floss?____________________________

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 mouth sores?................................ Yes No
Do your gums bleed or hurt?.. Yes No
Have you noticed any loose teeth / change in bite?.......... Yes No
Does food get caught in your teeth?................................ Yes No

Do you:

Clench or grind while awake or asleep?........................... Yes No
Mouth breathe while awake or asleep?............................ Yes No
Snore or have any other sleeping disorders?.................... Yes No

Have you ever had:

Orthodontic treatment?... Yes No
Oral Surgery?... Yes No
Periodontal Treatment?.. Yes No
A bite plate or mouth guard?.. Yes No
A serious injury to the mouth or head?........................... Yes No

TMJ Questionnaire - Have you experienced:

Clicking or popping of the jaw?....................................... Yes No
Pain? (joint, ear, side of face) …………………………… Yes No
Difficulty opening or closing mouth?.............................. Yes No
Difficulty chewing on either side?.................................. Yes No
Headaches, neckaches, shoulder aches?..................... Yes No
Sore jaw or teeth, especially in the morning?................. Yes No

Do you feel nervous about having dental treatment? .... Yes No

Please describe ____

Have you ever had an upsetting dental experience? .... Yes No

Please describe ____

Have you ever been sedated for dental treatment? .... Yes No

Please describe ____

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

If yes, please describe____

Patient Name:____

1. Physician's Name ______________________________Phone (   ) ____________________

Have you had any medical care in the past two years? .... Yes No

Describe____

2. Have you taken any medications or drugs in the past two years? .... Yes No

If yes, please list name and dosage____

3. Are you currently taking any medication, drugs, pills or herbal remedies including regular doses of aspirin? .... Yes No

If yes, please list name and dosage____

____

4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? .... Yes No

If yes, please list name and dosage____

5. Are you aware of having an allergic (or adverse) reaction to any substance or medication? .... Yes No

If yes, please specify____

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

❖ 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	AIDS/HIV positive………………	Yes	No
Congenital Heart Disease………	Yes	No	Thyroid Problems……………….	Yes	No	Hemophilia……………………….	Yes	No
Heart Murmer…………………….	Yes	No	Glaucoma………………………..	Yes	No	Sickle Cell Disease……………..	Yes	No
High/Low Blood Pressure………	Yes	No	Kidney Trouble………………….	Yes	No	Liver Disease / Jaundice………..	Yes	No
Mitral Valve Prolapse…………..	Yes	No	Emphysema…………………….	Yes	No	Neurological Disorders…………	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Hay Fever/Allergies/Hives……..	Yes	No	Epilepsy or Seizures……………	Yes	No
Rheumatic Fever………………...	Yes	No	Tuberculosis………………….....	Yes	No	Fainting or Dizzy Spells………..	Yes	No
Cortisone Medication…………..	Yes	No	Asthma……………………………	Yes	No	Nervous / Anxious………………	Yes	No
Swollen Ankles…………………..	Yes	No	Cancer……………………………	Yes	No	Psychiatric/Psychological Care..	Yes	No
Stroke…………………………….	Yes	No	Chemotherapy…………………..	Yes	No	Artificial Joints …………………..	Yes	No
Diet (Special/Restricted)……….	Yes	No	Radiation Therapy………………	Yes	No	Latex Sensitivity…………………	Yes	No

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

If yes, please list: ____

8. Do you smoke / chew tobacco or use other tobacco products? .... Yes No

If yes, how much?____

9. **Women:** Are you pregnant or think you could be pregnant? Yes ______ Months No **Nursing?** Yes No

10. 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 BP:____________ mmHg R / L Pulse:__________ bpm

Provider Signature______________________________Date:________