Michael C. Clausius DDS
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Oak Creek WI 53154

(414)762-0200



***Welcome!*** *So that we may provide you with the best possible care.*
*Please complete both pages of this medical/dental history form.*
*All information is completely confidential* ***(PLEASE PRINT)***

Name: _____ Date: _____

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: _____ State: _____ Zip: _____

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 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 | Yes | No |
| Have you noticed any loose teeth or change in your bite? | 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 |
| Have tired jaws, especially in the morning? | Yes | No |
| Mouth breathe, while awake or asleep? | Yes | No |
| Snore or have any other sleeping disorders? | Yes | No |
| Smoke/chew tobacco? | Yes | No |
| **Are you satisfied with your teeth's appearance?** | Yes | No |
| Would you like to keep all of your teeth all of your life? | Yes | No |

If you could change something about your smile, what would it be?

_____

**Have you ever had**:

| | | |
|---|---|---|
| Orthodontic treatment? | Yes | No |
| Oral surgery? | Yes | No |
| Periodontal treatment? | 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:**

| | | |
|---|---|---|
| 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 on either side of the mouth? | Yes | No |
| Headaches, neck aches or shoulder aches? | Yes | No |
| Sore muscles (neck, shoulders)? | 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? Yes No

If yes, please describe:_____

_____

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

If yes, please describe _____

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# MEDICAL HISTORY

Name: _____ Date: _____
(PLEASE PRINT)

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an Important interrelationship with the dentistry you will receive. Thank you for answering the following questions

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

(Physician's name)_____ (Physician's phone)_____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No _____

Have you ever had a serious head or neck injury? ) ☐ Yes ☐ No _____

Are you taking any medications, pills, or drugs?
(including aspirin or over the counter herbal) ☐ Yes ☐ No _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No Do you use controlled substances? ☐ Yes ☐ No

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

## Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

## Do you have, or have you had, any of the following?

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Chest Pains | ☐ Frequent Headaches | ☐ Irregular Heartbeat | ☐ Scarlet Fever |
| ☐ Alzheimer Disease | ☐ Cold Sores/Fever Blisters | ☐ Genital Herpes | ☐ Kidney Problems | ☐ Shingles |
| ☐ Anaphylaxis | ☐ Congenital Heart Disorder | ☐ Glaucoma | ☐ Leukemia | ☐ Sickle Cell Disease |
| ☐ Anemia | ☐ Convulsions | ☐ Hay Fever | ☐ Liver Disease | ☐ Sinus trouble |
| ☐ Angina | ☐ Cortisone Medicine | ☐ Heart Attack/Failure | ☐ Low Blood Pressure | ☐ Spina Bifida |
| ☐ Arthritis/Gout | ☐ Diabetes | ☐ Heart Murmur* | ☐ Lung Disease | ☐ Stomach/intestinal Disease |
| ☐ Artificial Heart Valve* | ☐ Drug Addiction | ☐ Heart Pace Maker* | ☐ Mitral Valve Prolapse* | ☐ Stroke |
| ☐ Artificial Joint* | ☐ Easily Winded | ☐ Heart Trouble/Disease | ☐ Pain in Jaw Joints | ☐ Swelling of Limbs |
| ☐ Asthma | ☐ Emphysema | ☐ Hemophilia | ☐ Parathyroid Disease | ☐ Thyroid Disease |
| ☐ Blood Disease | ☐ Epilepsy or Seizures | ☐ Hepatitis A | ☐ Psychiatric Care | ☐ Tonsillitis |
| ☐ Blood Transfusion | ☐ Excessive Bleeding | ☐ Hepatitis B or C | ☐ Radiation Treatments | ☐ Tuberculosis |
| ☐ Breathing Problem | ☐ Excessive Thirst | ☐ Herpes | ☐ Recent Weight Loss | ☐ Tumors or Growths |
| ☐ Bruise Easily | ☐ Fainting Spells/Dizziness | ☐ High Blood Pressure | ☐ Renal Dialysis | ☐ Ulcers |
| ☐ Cancer | ☐ Frequent Cough | ☐ Hives or Rash | ☐ Rheumatic Fever* | ☐ Venereal Disease |
| ☐ Chemotherapy | ☐ Frequent Diarrhea | ☐ Hypoglycemia | ☐ Rheumatism | ☐ Yellow Jaundice |

Have you ever had any serious illness, disease, condition not listed above? ☐ Yes ☐ No _____

Comments: _____

Do you have difficulty lying all the way back in a chair ? ☐ Yes ☐ No _____

*Condition may require medication

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing Incorrect information can be dangerous to my (or patient's) health. It is my responsibility to Inform the dental office of any changes in health or medication status.

_____ _____
SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

relationship to the patient ☐ Self ☐ Parent ☐ Guardian