Greenway Smiles
43490, Yukon Drive, Suite 114, Ashburn, VA 20147
571-222-4243

Dental / Medical History Form

Welcome! To help us provide the best possible care for your child, please complete both sides of this dental / medical history form. All information provided is completely confidential.

Patient Information

Date:	Last Name:	First Name:	Middle Name:
DOB:	Medical Alert:		

Dental

Your previous dentist's name and contact:

Dentist's Name: _____ Ph: _____

Address: _____

Date of last dental visit:	Date of last dental cleaning:	How often do you have a dental exam? _____ / day
How often does you child brush? _____ / day	How often do you Floss? _____ / day	What are other dental aids you use? (Toothpick, Interplak, etc.)

Dental conditions

Are any of your teeth sensitive to:

Hot/Cold ? ☐ Yes ☐ No Sweets? ☐ Yes ☐ No Biting / Chewing? ☐ Yes ☐ No

Do your gums bleed or hurt?	☐ Yes ☐ No	**Have you ever had**	
Do you frequently get cold sores, blisters, or any other oral lesions?	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
Do you have mouth odor or bad taste?	☐ Yes ☐ No	Oral Surgery	☐ Yes ☐ No
Have you ever experienced gum disease?	☐ Yes ☐ No	Gum treatment	☐ Yes ☐ No
Have you noticed loose teeth or change in your bite?	☐ Yes ☐ No	Your teeth adjusted or your bite adjusted	☐ Yes ☐ No
Do you bite your lips or cheeks regularly?	☐ Yes ☐ No	A night guard	☐ Yes ☐ No
Do you mouth breathe while awake/asleep?	☐ Yes ☐ No	**Have you experienced?**	☐ Yes ☐ No
Do you have tired jaws, especially in the morning?	☐ Yes ☐ No	Clicking or popping of jaw?	☐ Yes ☐ No
Do you clench or grid your teeth while awake/asleep?	☐ Yes ☐ No	Pain? (joint, ear, side of face)	☐ Yes ☐ No
Do you smoke / chew tobacco?	☐ Yes ☐ No	Difficulty of opening or closing your mouth?	☐ Yes ☐ No
		Head, neck, or shoulder aches?	☐ Yes ☐ No
		Are you satisfied with your teeth's appearance?	☐ Yes ☐ No
		Would you like to keep all your teeth?	☐ Yes ☐ No

Do you feel nervous about dental treatment?

If so, please describe: _____

Have you ever had an upsetting dental experience?

If yes, please describe: _____

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Physician Information

Have you ever been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
Name and Contact of Physician: _____

Have you taken any medication during the past two years? ☐ Yes ☐ No
Please name medications: _____

Are you taking any medications now? Including regular dosages of aspirin? ☐ Yes ☐ No
If yes, please list name and dosage:_____

Have you ever taken a medication for weight loss? ☐ Yes ☐ No

Are you aware of having allergic reaction to any medication or substance? ☐ Yes ☐ No
If yes, please list: _____

Have you ever been a patient in the hospital during the last five years? ☐ Yes ☐ No

List any hospitalizations, surgeries, serious illnesses:
_____

Medical conditions

Indicate which of the conditions you have now or had before.

Heart (surgery/disease)	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Heart murmur	☐ Yes ☐ No	Thyroid Problem	☐ Yes ☐ No	A.I.D.S	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	H.I.V. Positive	☐ Yes ☐ No
Mitral valve prolapse	☐ Yes ☐ No	Contact Lenses	☐ Yes ☐ No	Cold Sores/Fever	☐ Yes ☐ No
Artificial heart valve	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Cortisone Medication	☐ Yes ☐ No	Latex Sensitivity	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Swollen Ankles	☐ Yes ☐ No	Allergy / Hives	☐ Yes ☐ No	Neurological Disorder	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Diet (Special/Restricted)	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No	Fainting/Dizzy Spell	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Chemo Therapy	☐ Yes ☐ No	Nervous / Anxious	☐ Yes ☐ No
Kidney Trouble	☐ Yes ☐ No	Tumors	☐ Yes ☐ No	Psychological Care	☐ Yes ☐ No

Do you use more than one pillow to sleep? ☐ Yes ☐ No

Have you lost or gained more than 10 lbs in the past year? ☐ Yes ☐ No

Do you have or have you had any disease, conditions, or problems not listed? ☐ Yes ☐ No

If yes, please list: _____

Women: Are you pregnant? ☐ Yes Month: ☐ No
Nursing? ☐ Yes Month: ☐ No
Taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide my child 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 my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

Signature: *Date:*