

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 Name of Physician/and their specialty _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Excellent Good Fair Poor

- | | | | |
|--|------------|-----------|---|
| DO YOU HAVE or HAVE YOU EVER HAD: | YES | NO | |
| 1. hospitalization for illness or injury _____ | | | 27. arthritis _____ |
| 2. an allergic reaction to _____ | | | 28. autoimmune disease _____
(i.e. rheumatoid arthritis, lupus, scleroderma) |
| aspirin, ibuprofen, acetaminophen, codeine | | | 29. glaucoma _____ |
| penicillin | | | 30. contact lenses _____ |
| erythromycin | | | 31. head or neck injuries _____ |
| tetracycline | | | 32. epilepsy, convulsions (seizures) _____ |
| sulfa | | | 33. neurologic disorders (ADD/ADHD, prion disease) _____ |
| local anesthetic | | | 34. viral infections and cold sores _____ |
| fluoride | | | 35. any lumps or swelling in the mouth _____ |
| metals (nickel, gold, silver, _____) | | | 36. hives, skin rash, hay fever _____ |
| latex | | | 37. STI / STD / HPV _____ |
| other _____ | | | 38. hepatitis (type ____) _____ |
| 3. heart problems, or cardiac stent within the last six months _____ | | | 39. HIV / AIDS _____ |
| 4. history of infective endocarditis _____ | | | 40. tumor, abnormal growth _____ |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | | | 41. radiation therapy _____ |
| 6. pacemaker or implantable defibrillator _____ | | | 42. chemotherapy, immunosuppressive medication _____ |
| 7. orthopedic implant (joint replacement) _____ | | | 43. emotional difficulties _____ |
| 8. rheumatic or scarlet fever _____ | | | 44. psychiatric treatment _____ |
| 9. high or low blood pressure _____ | | | 45. antidepressant medication _____ |
| 10. a stroke (taking blood thinners) _____ | | | 46. alcohol / recreational drug use _____ |
| 11. anemia or other blood disorder _____ | | | ARE YOU: |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | | | 47. presently being treated for any other illness _____ |
| 13. emphysema, shortness of breath, sarcoidosis _____ | | | 48. aware of a change in your health in the last 24 hours
(i.e. fever, chills, new cough, or diarrhea) _____ |
| 14. tuberculosis, measles, chicken pox _____ | | | 49. taking medication for weight management _____ |
| 15. asthma _____ | | | 50. taking dietary supplements _____ |
| 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) | | | 51. often exhausted or fatigued _____ |
| 17. kidney disease _____ | | | 52. experiencing frequent headaches _____ |
| 18. liver disease _____ | | | 53. a smoker, smoked previously or use smokeless tobacco _____ |
| 19. jaundice _____ | | | 54. considered a touchy / sensitive person _____ |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | | | 55. often unhappy or depressed _____ |
| 21. hormone deficiency _____ | | | 56. FEMALE - taking birth control pills _____ |
| 22. high cholesterol or taking statin drugs _____ | | | 57. FEMALE - pregnant _____ |
| 23. diabetes (HbA1c = _____) _____ | | | 58. MALE - prostate disorders _____ |
| 24. stomach or duodenal ulcer _____ | | | |
| 25. digestive disorders (i.e. celiac disease, gastric reflux) _____ | | | |
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | | | |

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
 (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than a cleaning) ____/____/____
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____
2. Have you had an unfavorable dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____
6. Have you had any teeth removed? _____

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____
10. Is there anyone with a history of periodontal disease in your family? _____
11. Have you ever experienced gum recession? _____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
13. Have you experienced a burning sensation in your mouth? _____

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____
18. Do you have grooves or notches on your teeth near the gum line? _____
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
20. Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____
28. Do you place your tongue between your teeth or rest your teeth against your tongue? _____
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
30. Do you clench your teeth in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____
32. Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? _____
34. Have you ever whitened (bleached) your teeth? _____
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____