DENTAL HISTORY

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? Scale of 1 to 10 (very) __________ ❑ ❑
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 reactions to local anesthetic? ❑ ❑
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ❑ ❑
6. Have you had any teeth removed? ❑ ❑

Smile Characteristics

7. Is there anything about the appearance of your teeth that you would like to change? ❑ ❑
8. Have you ever whitened (bleached) your teeth? ❑ ❑
9. Are you self conscious about your teeth? ❑ ❑
10. Have you been disappointed with the appearance of previous dental work? ❑ ❑

Bite and Jaw Joint

11. Do you / would you have any problems chewing gum? ❑ ❑
12. Do you / would you have any problems chewing bagels or other hard foods? ❑ ❑
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ❑ ❑
14. Are your teeth crowding or developing spaces? ❑ ❑
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? ❑ ❑
16. Do you have any problems with sleep or wake up with an awareness of your teeth? ❑ ❑
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ❑ ❑
18. Do you have tension headaches or sore teeth? ❑ ❑
19. Do you wear or have you ever worn a bite appliance? ❑ ❑

Tooth Structure

20. Have you had any cavities within the past 3 years? ❑ ❑
21. Do you have a dry mouth? ❑ ❑
22. Are any teeth sensitive to hot, cold, biting or sweets? ❑ ❑
23 Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? ❑ ❑
24. Do you avoid brushing any part of your mouth? ❑ ❑

Gum and Bone

25. Have you ever been diagnosed or treated for periodontal (gum) disease? ❑ ❑
26. Have you ever experienced gum recession? ❑ ❑
27. Is there anyone with a history of periodontal disease in your family? ❑ ❑
28. Do your gums bleed when brushing, flossing or eating? ❑ ❑
29. Are your teeth becoming loose? ❑ ❑
30. Have you ever noticed an unpleasant taste or odor in your mouth? ❑ ❑
31. Have you experienced a burning sensation in your mouth? ❑ ❑

Patient's Signature______________________________ Date______________

Doctor's Signature______________________________ Date______________

Over

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

HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO
1. hospitalization for illness or injury	❑	❑
2. allergic reaction to		
❑ aspirin, ibuprofen, acetaminophen		
❑ penicillin		
❑ erythromycin		
❑ tetracycline		
❑ codeine		
❑ local anesthetic		
❑ fluoride		
❑ metals (gold, stainless steel)		
❑ latex		
❑ any other medications ____________		
3. heart problems	❑	❑
4. heart murmur	❑	❑
5. rheumatic fever	❑	❑
6. scarlet fever	❑	❑
7. high blood pressure	❑	❑
8. low blood pressure	❑	❑
9. a stroke	❑	❑
10. artificial prosthesis (i.e. heart valve or joints)	❑	❑
11. anemia or other blood disorder	❑	❑
12. prolonged bleeding due to a slight cut	❑	❑
13. emphysema	❑	❑
14. tuberculosis	❑	❑
15. asthma	❑	❑
16. sinus problems	❑	❑
17. kidney disease	❑	❑
18. liver disease	❑	❑
19. jaundice	❑	❑
20. thyroid or parathyroid disease	❑	❑
21. hormone deficiency	❑	❑
22. high cholesterol	❑	❑
23. diabetes	❑	❑
24. stomach or duodenal ulcer	❑	❑

	YES	NO
25. digestive disorders	❑	❑
26. arthritis	❑	❑
27. glaucoma	❑	❑
28. contact lenses	❑	❑
29. head or neck injuries	❑	❑
30. epilepsy, convulsions (seizures)	❑	❑
31. viral infections and cold sores	❑	❑
32. any lumps or swelling in the mouth	❑	❑
33. hives, skin rash, hay fever	❑	❑
34. venereal disease	❑	❑
35. hepatitis (type ___)	❑	❑
36. HIV / AIDS	❑	❑
37. tumor, abnormal growth	❑	❑
38. radiation therapy	❑	❑
39. chemotherapy	❑	❑
40. emotional problems	❑	❑
41. psychiatric treatment	❑	❑
42. antidepressant medication	❑	❑
43. alcohol / drug dependency	❑	❑
43b. HPV-Human Papillomavirus	❑	❑
ARE YOU:		
44. presently being treated for any other illness	❑	❑
45. aware of a change in your general health	❑	❑
46. taking medication for osteoporosis/osteopenia	❑	❑
47. often exhausted or fatigued	❑	❑
48. subject to frequent headaches	❑	❑
49. a heavy smoker (1 pack or more a day)	❑	❑
50. considered a touchy person	❑	❑
51. often unhappy or depressed	❑	❑
52. easily upset or irritated	❑	❑
53. FEMALE - taking birth control pills	❑	❑
54. FEMALE - pregnant	❑	❑
55. MALE - Prostate disorders	❑	❑

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

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

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

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______________

Over