

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

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, and at what age? _____
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma? _____

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 or painful sensation in your mouth not related to your teeth? _____

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 do you 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 back teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____
28. Do you place your tongue between your teeth or close 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 or grind your teeth together in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), 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 (shape, color, size)? _____
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 _____