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? _____	☐	☐
25.	Do you feel or notice any holes (i.e. pitting) in your teeth? _____	☐	☐
GUM AND BONE			
26.	Have you ever been diagnosed or treated for periodontal (gum) disease? _____	☐	☐
27.	Have you ever experienced gum recession? _____	☐	☐
28.	Is there anyone with a history of periodontal disease in your family? _____	☐	☐
29.	Do your gums bleed when brushing, flossing or eating? _____	☐	☐
30.	Are your teeth becoming loose? _____	☐	☐
31.	Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
32.	Have you experienced a burning sensation in your mouth? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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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 _____	☐	☐
2. an 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. breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
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 _____	☐	☐
25. digestive disorders (i.e. gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	☐	☐
27. arthritis _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

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

_____

List all 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 _____

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