

DENTAL HISTORY

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? _____

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. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
10. Have you been disappointed with the appearance of previous dental work? _____

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
12. Do you / would you have any problems chewing gum? _____
13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____
15. Are your teeth crowding or developing spaces? _____
16. Do you have more than one bite and squeeze to make your teeth fit together? _____
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
18. Do you clench your teeth in the daytime or make them sore? _____
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____
20. Do you wear or have you ever worn a bite appliance? _____

TOOTH STRUCTURE

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

GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____
31. Is there anyone with a history of periodontal disease in your family? _____
32. Have you ever experienced gum recession? _____
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
34. Have you experienced a burning sensation in your mouth? _____

Patient/ Parent / Guardian's Signature

Print Name

Date

Doctor's Signature

Date

MEDICAL HISTORY

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 _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>
2. an allergic reaction to	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis _____	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen			28. glaucoma _____	<input type="checkbox"/>
<input type="checkbox"/> codeine penicillin			29. contact lenses _____	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. head or neck injuries _____	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>
<input type="checkbox"/> sulpha local			32. neurologic problems (attention deficit disorder) _____	<input type="checkbox"/>
<input type="checkbox"/> anesthetic			33. viral infections and cold sores _____	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. any lumps or swelling in the mouth _____	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			35. hives, skin rash, hay fever _____	<input type="checkbox"/>
<input type="checkbox"/> latex			36. venereal disease _____	<input type="checkbox"/>
<input type="checkbox"/> other _____			37. hepatitis (type _____) _____	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS _____	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy _____	<input type="checkbox"/>
7. artificial prosthesis (heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional problems _____	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol / drug dependency _____	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>		
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>		
13. emphysema, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>		
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>		
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>		
16. breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>		
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>		
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>		
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>		
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>		
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>		
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>		
23. diabetes (HbA1c = _____)	<input type="checkbox"/>	<input type="checkbox"/>		
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>		
25. digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>		

ARE YOU:

46. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
47. aware of a change in your general health _____	<input type="checkbox"/>	<input type="checkbox"/>
48. taking medication for weight management (i.e. fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
49. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
50. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
51. subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
52. a smoker or smoked previously _____	<input type="checkbox"/>	<input type="checkbox"/>
53. considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
54. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
55. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
56. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
57. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>

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

To the best of my knowledge, the questions on dental & medical history have been accurately answered. If there is any change in health, I will inform the doctors at the next appointment without fail.

Patient / Parent / Guardian's Signature _____

Name Print _____

Date _____

Doctor's Signature _____

Date _____