MEDICAL HISTORY

Patient Name________________________ Nickname________________ Age ________

Name of Physician/and their specialty ____

Most recent physical exam ____________________ Purpose ________________________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE EVER HAD: **YES / NO**

1. Hospitalization for illness or injury________________ ☐ ☐
2. An allergic reaction to
   - ☐ Aspirin, ibuprofen, acetaminophen, codeine
   - ☐ Penicillin
   - ☐ Erythromycin
   - ☐ Tetracycline
   - ☐ Sulfa
   - ☐ Local anesthetic
   - ☐ Fluoride
   - ☐ Metals (nickel, gold, silver,____________)
   - ☐ Latex
   - ☐ Other ____________________
3. Heart problems or cardiac stent within the last 6 months ☐ ☐
4. History of infective endocarditis ______________ ☐ ☐
5. Artificial heart valve, repaired heart defect (PFO) _______ ☐ ☐
6. Pacemaker or implantable defibrillator ____________ ☐ ☐
7. Rheumatic or scarlet fever ________________ ☐ ☐
8. Artificial prosthesis (heart valve or joints) __________ ☐ ☐
9. High or low blood pressure ________________ ☐ ☐
10. A stroke (taking blood thinners) ______________ ☐ ☐
11. Anemia or other blood disorder ______________ ☐ ☐
12. Prolonged bleeding due to a slight cut (INR-3.5) _________ ☐ ☐
13. Emphysema, shortness of breath, sarcoidosis ________ ☐ ☐
14. Tuberculosis, measles, chicken pox ____________ ☐ ☐
15. Asthma ____________________________ ☐ ☐
16. Breathing or sleeping problems (i.e. sleep apnea, snoring, sinus) ☐ ☐
17. Kidney disease ________________________ ☐ ☐
18. Liver disease ________________________ ☐ ☐
19. Jaundice ___________________________ ☐ ☐
20. Thyroid, parathyroid disease or calcium deficiency_____ ☐ ☐
21. Hormone deficiency ____________________ ☐ ☐
22. High Cholesterol or taking statin drugs ____________ ☐ ☐
23. Diabetes (HbA1c=________) ______________ ☐ ☐
24. Stomach or duodenal ulcer ________________ ☐ ☐
25. Digestive disorders (i.e. celiac disease, gastric reflux) __ ☐ ☐

YES / NO

26. Osteoporosis/osteopenia ________________ ☐ ☐
27. Arthritis, rheumatoid arthritis, lupus _________ ☐ ☐
28. Glaucoma ________________________ ☐ ☐
29. Contact lenses _____________________ ☐ ☐
30. Head or neck injuries __________________ ☐ ☐
31. Epilepsy, convulsions (seizures) ____________ ☐ ☐
32. Neurologic disorders (ADD/ADHD, prion disease) _____ ☐ ☐
33. Viral infections and cold sores ______________ ☐ ☐
34. Any lumps or swelling in the mouth _________ ☐ ☐
35. Hives, skin rash, hay fever ______________ ☐ ☐
36. STI / STD ________________________ ☐ ☐
37. Hepatitis (Type____) __________________ ☐ ☐
38. HIV / AIDS ________________________ ☐ ☐
39. Tumor, abnormal growth ________________ ☐ ☐
40. Radiation therapy ____________________ ☐ ☐
41. Chemotherapy, immunosuppressive __________ ☐ ☐
42. Emotional problems ___________________ ☐ ☐
43. Psychiatric treatment __________________ ☐ ☐
44. Antidepressant medication _______________ ☐ ☐
45. Alcohol/ street drug use ________________ ☐ ☐

ARE YOU:

46. Presently being treated for any other illness ____ ☐ ☐
47. Aware of any change in your health in the last 24 hours (i.e. fever, chills, new cough or diarrhea) ______ ☐ ☐
48. Taking medication for weight management _____ ☐ ☐
49. Taking dietary supplements _______________ ☐ ☐
50. Often exhausted or fatigued ______________ ☐ ☐
51. Frequent headaches __________________ ☐ ☐
52. A smoker, smoked prev. or use smokeless tobacco ☐ ☐
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, genetic/development delay, 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

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

Patient's Signature ______________________________ **Date** _____/_____/_______

Doctor's Signature ______________________________ **Date** _____/_____/_______

DENTAL HISTORY

Name ______________________ How long have you been a patient here with our team? ____________

I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

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 ever had an unfavorable dental experience? ____________ ☐ ☐
3. Have you ever had complications with 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 & 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 and 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 on any part of your teeth? ____________ ☐ ☐
18. Do you have any 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 & 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 us being pushed back when you bite your teeth together? ____________ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, or other dry, hard foods? ____________ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ____________ ☐ ☐
25. Are your teeth crowding or developing spaces? ____________ ☐ ☐
26. Do you have to do more than one bite and squeeze to make your teeth fit together? ____________ ☐ ☐
27. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habit? ____________ ☐ ☐
28. Do you clench your teeth in the daytime or make them sore? ____________ ☐ ☐
29. Do you have any problems with sleep or wake up with an awareness of your teeth? ____________ ☐ ☐
30. Do you wear or have you ever worn a bite appliance? ____________ ☐ ☐

Smile Characteristics

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

Patient's Signature ______________________ **Date** _____/_____/______

Doctor's Signature ______________________ **Date** _____/_____/______