

# 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:

## PERSONAL HISTORY YES NO

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 YES NO

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 YES NO

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 YES NO

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 frequently get food caught between any teeth? \_\_\_\_\_

## GUM AND BONE YES NO

28. Do your gums bleed or are they painful 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's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# 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 _____	<input type="checkbox"/>	<input type="checkbox"/>	26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	an allergic reaction to _____			27.	arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			28.	glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> penicillin			29.	contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> erythromycin			30.	head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> tetracycline			31.	epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> sulfa			32.	neurologic problems (attention deficit disorder) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> local anesthetic			33.	viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> fluoride			34.	any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> metals (nickel, gold, silver, _____)			35.	hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> latex			36.	venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> other _____			37.	hepatitis (type _____) _____	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
4.	history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39.	tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5.	artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	40.	radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6.	pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41.	chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7.	artificial prosthesis (heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	42.	emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8.	rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43.	psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9.	high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44.	antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10.	a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45.	alcohol / street drug use _____	<input type="checkbox"/>	<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"/>	<b>ARE YOU:</b>			
13.	emphysema, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	46.	presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
14.	tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47.	aware of a change in your health (i.e. fever, new cough) _____	<input type="checkbox"/>	<input type="checkbox"/>
15.	asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	48.	taking medication for weight management (i.e. fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
16.	breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	49.	taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
17.	kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50.	often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
18.	liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51.	experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
19.	jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	52.	a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
20.	thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	53.	considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
21.	hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54.	often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
22.	high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	55.	FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
23.	diabetes (HbA1c = _____)	<input type="checkbox"/>	<input type="checkbox"/>	56.	FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
24.	stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	57.	MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
25.	digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>				

Describe any current medical treatment, impending surgery, 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 \_\_\_\_\_

