

# 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 or bad reaction to any of the following:<br><input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine<br><input type="checkbox"/> penicillin<br><input type="checkbox"/> erythromycin<br><input type="checkbox"/> tetracycline<br><input type="checkbox"/> sulfa<br><input type="checkbox"/> local anesthetic<br><input type="checkbox"/> fluoride<br><input type="checkbox"/> metals (nickel, gold, silver, _____)<br><input type="checkbox"/> latex<br><input type="checkbox"/> nuts _____<br><input type="checkbox"/> fruit _____<br><input type="checkbox"/> other _____ | <input type="checkbox"/> | <input type="checkbox"/> | 27. arthritis _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last six months _____  | <input type="checkbox"/> | <input type="checkbox"/> | 28. autoimmune disease _____<br>(i.e. rheumatoid arthritis, lupus, scleroderma)                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____  | <input type="checkbox"/> | <input type="checkbox"/> | 29. glaucoma _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____  | <input type="checkbox"/> | <input type="checkbox"/> | 30. contact lenses _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____   | <input type="checkbox"/> | <input type="checkbox"/> | 31. head or neck injuries _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. orthopedic implant (joint replacement) _____   | <input type="checkbox"/> | <input type="checkbox"/> | 32. epilepsy, convulsions (seizures) _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. rheumatic or scarlet fever _____   | <input type="checkbox"/> | <input type="checkbox"/> | 33. neurologic disorders (ADD/ADHD, prion disease) _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure _____   | <input type="checkbox"/> | <input type="checkbox"/> | 34. viral infections and cold sores _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) _____  | <input type="checkbox"/> | <input type="checkbox"/> | 35. any lumps or swelling in the mouth _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____  | <input type="checkbox"/> | <input type="checkbox"/> | 36. hives, skin rash, hay fever _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____  | <input type="checkbox"/> | <input type="checkbox"/> | 37. STI/STD/HPV _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. pneumonia, emphysema, shortness of breath, sarcoidosis _____  | <input type="checkbox"/> | <input type="checkbox"/> | 38. hepatitis (type _____) _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis, measles, chicken pox _____  | <input type="checkbox"/> | <input type="checkbox"/> | 39. HIV/AIDS _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma _____  | <input type="checkbox"/> | <input type="checkbox"/> | 40. tumor, abnormal growth _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____  | <input type="checkbox"/> | <input type="checkbox"/> | 41. radiation therapy _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease _____  | <input type="checkbox"/> | <input type="checkbox"/> | 42. chemotherapy, immunosuppressive medication _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease _____   | <input type="checkbox"/> | <input type="checkbox"/> | 43. emotional difficulties _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice _____  | <input type="checkbox"/> | <input type="checkbox"/> | 44. psychiatric treatment _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid, parathyroid disease, or calcium deficiency _____   | <input type="checkbox"/> | <input type="checkbox"/> | 45. antidepressant medication _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency _____  | <input type="checkbox"/> | <input type="checkbox"/> | 46. alcohol/recreational drug use _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol or taking statin drugs _____   | <input type="checkbox"/> | <input type="checkbox"/> | <b>ARE YOU:</b>   |                          |                          |
| 23. diabetes (HbA1c = _____)  | <input type="checkbox"/> | <input type="checkbox"/> | 47. presently being treated for any other illness _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. stomach or duodenal ulcer _____   | <input type="checkbox"/> | <input type="checkbox"/> | 48. aware of a change in your health in the last 24 hours<br>(i.e. fever, chills, new cough, or diarrhea) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____   | <input type="checkbox"/> | <input type="checkbox"/> | 49. taking medication for weight management _____   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 50. taking dietary supplements _____  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 51. often exhausted or fatigued _____   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 52. experiencing frequent headaches _____   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 53. a smoker, smoked previously or use smokeless tobacco _____  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 54. considered a touchy/sensitive person _____  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 55. often unhappy or depressed _____  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 56. taking birth control pills _____  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 57. currently pregnant _____  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 58. diagnosed with a prostate disorder _____  | <input type="checkbox"/> | <input type="checkbox"/> |

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, 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 try to 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 \_\_\_\_\_