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 or bad reaction to any of the following: ☐ ☐
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ chlorhexidine (CHX)
   - ☐ metals (nickel, gold, silver,)
   - ☐ latex
   - ☐ nuts
   - ☐ fruit
   - ☐ other
3. heart problems, or cardiac stent within the last six months____ ☐ ☐
4. history of infective endocarditis ______ ☐ ☐
5. artificial heart valve, repaired heart defect (PFO) ______ ☐ ☐
6. pacemaker or implantable defibrillator ______ ☐ ☐
7. orthopedic implant (joint replacement) ______ ☐ ☐
8. rheumatic or scarlet fever ______ ☐ ☐
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. pneumonia, emphysema, shortness of breath, sarcoidosis ______ ☐ ☐
14. chronic ear infections, tuberculosis, measles, chicken pox ______ ☐ ☐
15. asthma ______ ☐ ☐
16. breathing or sleep problems (e.g., 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 or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ______ ☐ ☐

YES NO

26. osteoporosis/osteopenia (e.g., taking bisphosphonates) ______ ☐ ☐
27. arthritis ______ ☐ ☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) ______ ☐ ☐
29. glaucoma ______ ☐ ☐
30. contact lenses ______ ☐ ☐
31. head or neck injuries ______ ☐ ☐
32. epilepsy, convulsions (seizures) ______ ☐ ☐
33. neurologic disorders (ADD/ADHD, prion disease) ______ ☐ ☐
34. viral infections and cold sores ______ ☐ ☐
35. any lumps or swelling in the mouth ______ ☐ ☐
36. hives, skin rash, hay fever ______ ☐ ☐
37. STI/STD/HPV ______ ☐ ☐
38. hepatitis (type_____) ______ ☐ ☐
39. HIV/AIDS ______ ☐ ☐
40. tumor, abnormal growth ______ ☐ ☐
41. radiation therapy ______ ☐ ☐
42. chemotherapy, immunosuppressive medication ______ ☐ ☐
43. emotional difficulties ______ ☐ ☐
44. psychiatric treatment ______ ☐ ☐
45. antidepressant medication ______ ☐ ☐
46. alcohol/recreational drug use ______ ☐ ☐

ARE YOU:

47. presently being treated for any other illness ______ ☐ ☐
48. aware of a change in your health in the last 24 hours ______ (e.g., fever, chills, new cough, or diarrhea) ☐ ☐
49. taking medication for weight management ______ ☐ ☐
50. taking dietary supplements ______ ☐ ☐
51. often exhausted or fatigued ______ ☐ ☐
52. experiencing frequent headaches ______ ☐ ☐
53. a smoker, smoked previously or use smokeless tobacco ☐ ☐
54. considered a touchy/sensitive person ______ ☐ ☐
55. often unhappy or depressed ______ ☐ ☐
56. taking birth control pills ______ ☐ ☐
57. currently pregnant ______ ☐ ☐
58. diagnosed with a prostate disorder ______ ☐ ☐

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 ____________

ASA ______ (1-6) ○ ○ ○

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 or 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 dificulty 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 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 ______________ ☐