# 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) _____ ☐ ☐
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 _____

# 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 _____