

# 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? \_\_\_\_\_
6. Have you had any teeth removed? \_\_\_\_\_

## 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 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 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 teeth together? \_\_\_\_\_
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry 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 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 habits? \_\_\_\_\_
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 \_\_\_\_\_

# 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

- |  |            |           |   |
|--|------------|-----------|---|
| <b>DO YOU HAVE or HAVE YOU EVER HAD:</b>                                 | <b>YES</b> | <b>NO</b> |   |
| 1. hospitalization for illness or injury _____                           |            |           | 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____   |
| 2. an allergic reaction to _____   |            |           | 27. arthritis, rheumatoid arthritis, lupus _____  |
| aspirin, ibuprofen, acetaminophen, codeine _____                         |            |           | 28. glaucoma _____  |
| penicillin _____   |            |           | 29. contact lenses _____  |
| erythromycin _____   |            |           | 30. head or neck injuries _____   |
| tetracycline _____   |            |           | 31. epilepsy, convulsions (seizures) _____  |
| sulfa _____  |            |           | 32. neurologic disorders (ADD/ADHD, prion disease) _____  |
| local anesthetic _____   |            |           | 33. viral infections and cold sores _____   |
| fluoride _____   |            |           | 34. any lumps or swelling in the mouth _____  |
| metals (nickel, gold, silver, _____)                                     |            |           | 35. hives, skin rash, hay fever _____   |
| latex _____  |            |           | 36. STI/STD _____   |
| other _____  |            |           | 37. hepatitis (type _____) _____  |
| 3. heart problems, or cardiac stent within the last six months _____     |            |           | 38. HIV / AIDS _____  |
| 4. history of infective endocarditis _____                               |            |           | 39. tumor, abnormal growth _____  |
| 5. artificial heart valve, repaired heart defect (PFO) _____             |            |           | 40. radiation therapy _____   |
| 6. pacemaker or implantable defibrillator _____                          |            |           | 41. chemotherapy, immunosuppressive _____   |
| 7. artificial prosthesis (heart valve or joints) _____                   |            |           | 42. emotional problems _____  |
| 8. rheumatic or scarlet fever _____                                      |            |           | 43. psychiatric treatment _____   |
| 9. high or low blood pressure _____                                      |            |           | 44. antidepressant medication _____   |
| 10. a stroke (taking blood thinners) _____                               |            |           | 45. alcohol / street drug use _____   |
| 11. anemia or other blood disorder _____                                 |            |           |   |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____             |            |           | <b>ARE YOU:</b>   |
| 13. emphysema, shortness of breath, sarcoidosis _____                    |            |           | 46. presently being treated for any other illness _____   |
| 14. tuberculosis, measles, chicken pox _____                             |            |           | 47. aware of a change in your health in the last 24 hours<br>(i.e. fever, chills, new cough, or diarrhea) _____ |
| 15. asthma _____   |            |           | 48. taking medication for weight management (i.e. fen-phen) _____   |
| 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____ |            |           | 49. taking dietary supplements _____  |
| 17. kidney disease _____   |            |           | 50. often exhausted or fatigued _____   |
| 18. liver disease _____  |            |           | 51. experiencing frequent headaches _____   |
| 19. jaundice _____   |            |           | 52. a smoker, smoked previously or use smokeless tobacco _____  |
| 20. thyroid, parathyroid disease, or calcium deficiency _____            |            |           | 53. considered a touchy person _____  |
| 21. hormone deficiency _____   |            |           | 54. often unhappy or depressed _____  |
| 22. high cholesterol or taking statin drugs _____                        |            |           | 55. FEMALE - taking birth control pills _____   |
| 23. diabetes (HbA1c = _____) _____                                       |            |           | 56. FEMALE - pregnant _____   |
| 24. stomach or duodenal ulcer _____                                      |            |           | 57. MALE - prostate disorders _____   |
| 25. digestive disorders (i.e. celiac disease, gastric reflux) _____      |            |           |   |

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 \_\_\_\_\_