

# DENTAL HISTORY

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
Referred by FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ 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 or missing teeth that never developed? \_\_\_\_\_

## 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 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 becoming more crooked, crowded, or overlapped? \_\_\_\_\_
26. Are your teeth developing spaces or becoming more loose? \_\_\_\_\_
27. Do you have more than one bite, squeeze, 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 your teeth in the daytime or make them sore? \_\_\_\_\_
31. Do you have any problems with sleep (i.e. restlessness), 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? \_\_\_\_\_
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 \_\_\_\_\_



# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_  
 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

- |   |   |
|---|---|
| <ol style="list-style-type: none"> <li>1. hospitalization for illness or injury _____</li> <li>2. an allergic reaction to _____<br/>           aspirin, ibuprofen, acetaminophen, codeine<br/>           penicillin<br/>           erythromycin<br/>           tetracycline<br/>           sulfa<br/>           local anesthetic<br/>           fluoride<br/>           metals (nickel, gold, silver, _____)<br/>           latex<br/>           other _____</li> <li>3. heart problems, or cardiac stent within the last six months _____</li> <li>4. history of infective endocarditis _____</li> <li>5. artificial heart valve, repaired heart defect (PFO) _____</li> <li>6. pacemaker or implantable defibrillator _____</li> <li>7. orthopedic implant (joint replacement) _____</li> <li>8. rheumatic or scarlet fever _____</li> <li>9. high or low blood pressure _____</li> <li>10. a stroke (taking blood thinners) _____</li> <li>11. anemia or other blood disorder _____</li> <li>12. prolonged bleeding due to a slight cut (INR &gt; 3.5) _____</li> <li>13. emphysema, shortness of breath, sarcoidosis _____</li> <li>14. tuberculosis, measles, chicken pox _____</li> <li>15. asthma _____</li> <li>16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____</li> <li>17. kidney disease _____</li> <li>18. liver disease _____</li> <li>19. jaundice _____</li> <li>20. thyroid, parathyroid disease, or calcium deficiency _____</li> <li>21. hormone deficiency _____</li> <li>22. high cholesterol or taking statin drugs _____</li> <li>23. diabetes (HbA1c = _____) _____</li> <li>24. stomach or duodenal ulcer _____</li> <li>25. digestive disorders (i.e. celiac disease, gastric reflux) _____</li> <li>26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____</li> </ol> | <ol style="list-style-type: none"> <li>27. arthritis _____</li> <li>28. autoimmune disease _____<br/>           (i.e. rheumatoid arthritis, lupus, scleroderma)</li> <li>29. glaucoma _____</li> <li>30. contact lenses _____</li> <li>31. head or neck injuries _____</li> <li>32. epilepsy, convulsions (seizures) _____</li> <li>33. neurologic disorders (ADD/ADHD, prion disease) _____</li> <li>34. viral infections and cold sores _____</li> <li>35. any lumps or swelling in the mouth _____</li> <li>36. hives, skin rash, hay fever _____</li> <li>37. STI / STD / HPV _____</li> <li>38. hepatitis (type _____) _____</li> <li>39. HIV / AIDS _____</li> <li>40. tumor, abnormal growth _____</li> <li>41. radiation therapy _____</li> <li>42. chemotherapy, immunosuppressive medication _____</li> <li>43. emotional difficulties _____</li> <li>44. psychiatric treatment _____</li> <li>45. antidepressant medication _____</li> <li>46. alcohol / recreational drug use _____</li> </ol> <p><b>ARE YOU:</b></p> <ol style="list-style-type: none"> <li>47. presently being treated for any other illness _____</li> <li>48. aware of a change in your health in the last 24 hours<br/>           (i.e. fever, chills, new cough, or diarrhea) _____</li> <li>49. taking medication for weight management _____</li> <li>50. taking dietary supplements _____</li> <li>51. often exhausted or fatigued _____</li> <li>52. experiencing frequent headaches _____</li> <li>53. a smoker, smoked previously or use smokeless tobacco _____</li> <li>54. considered a touchy / sensitive person _____</li> <li>55. often unhappy or depressed _____</li> <li>56. taking birth control pills _____</li> <li>57. currently pregnant _____</li> <li>58. prostate disorders _____</li> </ol> |
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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 \_\_\_\_\_