

DENTAL HISTORY

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) [____] _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE CHARACTERISTICS

- | | | |
|--|--------------------------|--------------------------|
| 7. Is there anything about the appearance of your teeth that you would like to change? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever whitened (bleached) your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been disappointed with the appearance of previous dental work? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT

- | | | |
|--|--------------------------|--------------------------|
| 11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you / would you have any problems chewing gum? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are your teeth crowding or developing spaces? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have more than one bite and squeeze to make your teeth fit together? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you clench your teeth in the daytime or make them sore? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you wear or have you ever worn a bite appliance? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

TOOTH STRUCTURE

- | | | |
|--|--------------------------|--------------------------|
| 21. Have you had any cavities within the past 3 years? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you have grooves or notches on your teeth near the gum line? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you get food caught between any teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

GUM AND BONE

- | | | |
|---|--------------------------|--------------------------|
| 28. Do your gums bleed when brushing or flossing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Is there anyone with a history of periodontal disease in your family? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you ever experienced gum recession? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you experienced a burning sensation in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Patient/ Parent / Guardian's Signature

Print Name

Date

Doctor's Signature

Date

MEDICAL HISTORY

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 reaction to	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen			28. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> codeine penicillin			29. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulpha local			32. neurologic problems (attention deficit disorder) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> anesthetic			33. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			35. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			37. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7. artificial prosthesis (heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol / drug dependency _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>			
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
13. emphysema, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	46. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47. aware of a change in your general health _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	48. taking medication for weight management (i.e. fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51. subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	52. a smoker or smoked previously _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	53. considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	55. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>	56. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	57. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
25. digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

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

To the best of my knowledge, the questions on dental & medical history have been accurately answered. If there is any change in health, I will inform the doctors at the next appointment without fail.

_____	_____	_____
Patient / Parent / Guardian's Signature	Name Print	Date
_____	_____	_____
Doctor's Signature		Date