# 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

| DO YOU HAVE or HAVE YOU EVER HAD: | YES | NO |
|---|---|---|
| 1. hospitalization for illness or injury_____ | ☐ | ☐ |
| 2. an allergic reaction to | | |
| ☐ aspirin, ibuprofen, acetaminophen, codeine | | |
| ☐ penicillin | | |
| ☐ erythromycin | | |
| ☐ tetracycline | | |
| ☐ sulfa | | |
| ☐ local anesthetic | | |
| ☐ fluoride | | |
| ☐ metals (nickel, gold, silver, _____) | | |
| ☐ latex | | |
| ☐ 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. artificial prosthesis (heart valve or joints) _____ | ☐ | ☐ |
| 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. emphysema, shortness of breath, sarcoidosis _____ | ☐ | ☐ |
| 14. tuberculosis, measles, chicken pox_____ | ☐ | ☐ |
| 15. asthma_____ | ☐ | ☐ |
| 16. breathing or sleep problems (i.e. 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 disorders (i.e. celiac disease, gastric reflux) _____ | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __ | ☐ | ☐ |
| 27. arthritis, rheumatoid arthritis, lupus _____ | ☐ | ☐ |
| 28. glaucoma_____ | ☐ | ☐ |
| 29. contact lenses _____ | ☐ | ☐ |
| 30. head or neck injuries _____ | ☐ | ☐ |
| 31. epilepsy, convulsions (seizures) _____ | ☐ | ☐ |
| 32. neurologic disorders (ADD/ADHD, prion disease) _____ | ☐ | ☐ |
| 33. viral infections and cold sores _____ | ☐ | ☐ |
| 34. any lumps or swelling in the mouth_____ | ☐ | ☐ |
| 35. hives, skin rash, hay fever_____ | ☐ | ☐ |
| 36. STI / STD _____ | ☐ | ☐ |
| 37. hepatitis (type ___) _____ | ☐ | ☐ |
| 38. HIV / AIDS _____ | ☐ | ☐ |
| 39. tumor, abnormal growth_____ | ☐ | ☐ |
| 40. radiation therapy_____ | ☐ | ☐ |
| 41. chemotherapy, immunosuppressive_____ | ☐ | ☐ |
| 42. emotional problems _____ | ☐ | ☐ |
| 43. psychiatric treatment_____ | ☐ | ☐ |
| 44. antidepressant medication _____ | ☐ | ☐ |
| 45. alcohol / street drug use _____ | ☐ | ☐ |
| **ARE YOU:** | | |
| 46. presently being treated for any other illness _____ | ☐ | ☐ |
| 47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____ | ☐ | ☐ |
| 48. taking medication for weight management (i.e. fen-phen) | ☐ | ☐ |
| 49. taking dietary supplements_____ | ☐ | ☐ |
| 50. often exhausted or fatigued _____ | ☐ | ☐ |
| 51. experiencing frequent headaches_____ | ☐ | ☐ |
| 52. a smoker, smoked previously or use smokeless tobacco _ | ☐ | ☐ |
| 53. considered a touchy person _____ | ☐ | ☐ |
| 54. often unhappy or depressed_____ | ☐ | ☐ |
| 55. FEMALE - taking birth control pills _____ | ☐ | ☐ |
| 56. FEMALE - pregnant _____ | ☐ | ☐ |
| 57. MALE - prostate disorders _____ | ☐ | ☐ |

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 _____