Medical History

Patient Name_____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	____	____
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 (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 (celiac, gastric reflux, bulimia, anorexia)	____	____
26. Osteoporosis/osteopenia (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 hrs (i.e. fever, chills, new cough, or diarrhea)	____	____
48. Taking medication for weight management	____	____
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 that 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_____

DENTAL HISTORY

Patient Name_____Age_____

Referred by_____How would you rate the condition of your mouth? ____Excellent ____Good _____Fair ____Poor

Previous Dentist_____How long had you been a patient? _____

Date of most recent dental exam _____ Date of most recent x-rays_____

Date of most recent dental treatment (Other than a cleaning) _____

I routinely see my dentist every ____3mo ____4mo ____6mo ____12mo ____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?	_____	_____
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 or 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 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 to little or do you have any 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 do you avoid brushing any part of your mouth?	_____	_____
18. Do you have any grooves or notches on your teeth near the gum line?	_____	_____
19. Dave you ever broken teeth, chipped teeth, or had a toothache or cracked a filling?	_____	_____
20. Do you frequently get food caught between any teeth?	_____	_____
BITE AND JAW JOINT 		
21. Do you have any 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, 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 loose?	_____	_____
27. Do you have trouble finding your bite, or need to squeeze, tap, or shift your teeth to make them 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, 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_____