# 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 | | |
| ☐ sulpha | | |
| ☐ 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, sarcoidosis _____ | ☐ | ☐ |
| 14. tuberculosis _____ | ☐ | ☐ |
| 15. asthma _____ | ☐ | ☐ |
| 16. breathing or sleep problems (i.e. 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. gastric reflux)_____ | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __ | ☐ | ☐ |
| 27. arthritis _____ | ☐ | ☐ |
| 28. glaucoma_____ | ☐ | ☐ |
| 29. contact lenses _____ | ☐ | ☐ |
| 30. head or neck injuries _____ | ☐ | ☐ |
| 31. epilepsy, convulsions (seizures) _____ | ☐ | ☐ |
| 32. neurologic problems (attention deficit disorder)_____ | ☐ | ☐ |
| 33. viral infections and cold sores _____ | ☐ | ☐ |
| 34. any lumps or swelling in the mouth_____ | ☐ | ☐ |
| 35. hives, skin rash, hay fever_____ | ☐ | ☐ |
| 36. venereal disease _____ | ☐ | ☐ |
| 37. hepatitis (type ___) _____ | ☐ | ☐ |
| 38. HIV / AIDS _____ | ☐ | ☐ |
| 39. tumor, abnormal growth_____ | ☐ | ☐ |
| 40. radiation therapy_____ | ☐ | ☐ |
| 41. chemotherapy_____ | ☐ | ☐ |
| 42. emotional problems _____ | ☐ | ☐ |
| 43. psychiatric treatment_____ | ☐ | ☐ |
| 44. antidepressant medication _____ | ☐ | ☐ |
| 45. alcohol / drug dependency _____ | ☐ | ☐ |
| **ARE YOU:** | | |
| 46. presently being treated for any other illness _____ | ☐ | ☐ |
| 47. aware of a change in your general health _____ | ☐ | ☐ |
| 48. taking medication for weight management (i.e. fen-phen) | ☐ | ☐ |
| 49. taking dietary supplements_____ | ☐ | ☐ |
| 50. often exhausted or fatigued _____ | ☐ | ☐ |
| 51. subject to frequent headaches _____ | ☐ | ☐ |
| 52. a smoker or smoked previously _____ | ☐ | ☐ |
| 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, 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

**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

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:**

## PERSONAL HISTORY

| | | YES | NO |
|---|---|---|---|
| 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? _____ | ☐ | ☐ |

## SMILE CHARACTERISTICS

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

## BITE AND JAW JOINT

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

## TOOTH STRUCTURE

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

## GUM AND BONE

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

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____