MEDICAL HISTORY

Patient Name _____ **Date of Birth** _____ **Age** _____

Name of Physician/and their specialty _____

Most recent physical examination _____ **Purpose** _____

What is your estimate of your general health? ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

HAVE YOU EVER HAD THE FOLLOWING:	**YES**	**NO**
1. Hospitalization for illness or injury _____	☐	☐
Describe: _____		
_____		
_____		

2a. allergic reaction to:
- ☐ aspirin,ibuprofen,acetaminophen
- ☐ penicillin
- ☐ erythromycin
- ☐ tetracycline
- ☐ codeine
- ☐ local anesthetic
- ☐ fluoride
- ☐ metals (gold, stainless steel)
- ☐ latex
- ☐ any other medications _____

2b. seasonal allergies
- ☐ generalized/chronic
- ☐ grass
- ☐ pollen
- ☐ mold
- ☐ other

3. heart problems _____	☐	☐
4. heart murmur _____	☐	☐
5. rheumatic fever _____	☐	☐
6. scarlet fever _____	☐	☐
7. high blood pressure _____	☐	☐
8. low blood pressure _____	☐	☐
9. stroke _____	☐	☐
10. artificial prosthesis (i.e. heart valve or joints) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut _____	☐	☐
13. emphysema _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. sinus problems _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid or parathyroid disease _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol _____	☐	☐
23. diabetes _____	☐	☐
a. controlled by ☐ Insulin ☐ Oral-Medication ☐ diet contol		
b. Last HBA1C Test Date _____ Result _____		
24. stomach or duodenal ulcer _____		

25. digestive disorders (colitis, irritable bowel, reflux) _____	☐	☐
26. arthritis _____	☐	☐
a. Other Bone, Joint, or Muscle Diseases _____	☐	☐
27. head or neck injuries _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. epilepsy, convulsions (seizures) _____	☐	☐
31. neurologic problems _____	☐	☐
32. viral infections and cold sores _____	☐	☐
33. any lumps or swelling in the mouth _____	☐	☐
34. hives, skin rash, hay fever _____	☐	☐
35. venereal disease _____	☐	☐
36. hepatitis (type ___) _____	☐	☐
37. HIV / AIDS _____	☐	☐
38. tumor, abnormal growth _____	☐	☐
39. radiation therapy _____	☐	☐
40. chemotherapy _____	☐	☐
41. emotional problems _____	☐	☐
42. psychiatric treatment _____	☐	☐
43. antidepressant medication _____	☐	☐
44. alcohol / drug dependency _____	☐	☐
45. do you snore? _____	☐	☐
46. have you ever been diagnosed with sleep apnea? _____	☐	☐
47. do you ever awaken gasping for breath? _____	☐	☐
48. are you a mouth breather? _____	☐	☐
49. have you ever had problems with enlarged tonsils? ____	☐	☐

ARE YOU:

50. presently being treated for any other illness _____	☐	☐
51. aware of a change in your general health _____	☐	☐
52. taking medication for osteoporosis/osteopenia _____	☐	☐
53. often exhausted or fatigued _____	☐	☐
54. subject to frequent headaches _____	☐	☐
55. a smoker, smoked previously, or use chewing tobacco _	☐	☐
56. considered a touchy person _____	☐	☐
57. often unhappy or depressed _____	☐	☐
58. FEMALE - taking birth control pills _____	☐	☐
59. FEMALE - pregnant _____	☐	☐
60. MALE - Prostate disorders _____	☐	☐

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

_____

List any 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 had 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 cleaning) _____ /_____ /_____ Did you have any incomplete treatment? ☐ Yes ☐ No

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	**L**	**M**	**H**		
1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____				☐	☐
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 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	**L**	**M**	**H**		
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. Are you self conscious about your teeth? _____				☐	☐
10. Have you been disappointed with the appearance of previous dental work? _____				☐	☐
BITE AND JAW JOINT	**L**	**M**	**H**		
11. Do you / would you have any problems chewing gum? _____				☐	☐
12. Do you / would you have any problems chewing bagels or other hard foods? _____				☐	☐
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____				☐	☐
14. Are your teeth crowding or developing spaces? _____				☐	☐
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____				☐	☐
16. Do you have any problems with sleep or wake up with an awareness of your teeth? _____				☐	☐
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____				☐	☐
18. Do you have tension headaches or sore teeth? _____				☐	☐
19. Do you wear or have you ever worn a bite appliance? _____				☐	☐
TOOTH STRUCTURE	**L**	**M**	**H**		
20. Have you had any cavities within the past 3 years? _____				☐	☐
21. Do you have a dry mouth? _____				☐	☐
22. Are any teeth sensitive to hot, cold, biting or sweets? _____				☐	☐
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____				☐	☐
24. Do you avoid brushing any part of your mouth? _____				☐	☐
GUM AND BONE	**L**	**M**	**H**		
25. Have you ever been diagnosed or treated for periodontal (gum) disease? _____				☐	☐
26. Have you ever experienced gum recession? _____				☐	☐
27. Is there anyone with a history of periodontal disease in your family? _____				☐	☐
28. Do your gums bleed when brushing, flossing or eating? _____				☐	☐
29. Are your teeth becoming loose? _____				☐	☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____				☐	☐
31. Have you experienced a burning sensation in your mouth? _____				☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____