# MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Address _____

Telephone _____

Most recent physical examination _____ Purpose _____

| 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, sarcoldosis _____ | ❑ | ❑ |
| 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 _____ | ❑ | ❑ |

| DO YOU HAVE or HAVE YOU EVER HAD: | YES | NO |
|---|---|---|
| 23. diabetes (HbA1c = _____ ) _____ | ❑ | ❑ |
| 24. stomach or duodenal ulcer _____ | ❑ | ❑ |
| 25. digestive disorders (i.e. gastric reflux) _____ | ❑ | ❑ |
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | ❑ | ❑ |
| 27. arthritis _____ | ❑ | ❑ |
| 28. glaucoma _____ | ❑ | ❑ |
| 29. contact lenses _____ | ❑ | ❑ |
| 30. head or neck injuries _____ | ❑ | ❑ |
| 31. epilepsy, convulsions (seizures) _____ | ❑ | ❑ |
| 32. viral infections and cold sores _____ | ❑ | ❑ |
| 33. any lumps or swelling in the mouth _____ | ❑ | ❑ |
| 34. hepatitis (type _____) _____ | ❑ | ❑ |
| 35. HIV/AIDS _____ | ❑ | ❑ |
| 36. tumor, abnormal growth _____ | ❑ | ❑ |
| 37. radiation therapy _____ | ❑ | ❑ |
| 38. chemotherapy _____ | ❑ | ❑ |
| 39. emotional problems _____ | ❑ | ❑ |
| 40. psychiatric treatment _____ | ❑ | ❑ |
| 41. antidepressant medication _____ | ❑ | ❑ |
| 42. alcohol/drug dependency _____ | ❑ | ❑ |
| **ARE YOU:** | **YES** | **NO** |
| 43. presently being treated for any other illness _____ | ❑ | ❑ |
| 44. aware of a change in your general health _____ | ❑ | ❑ |
| 45. taking dietary supplements _____ | ❑ | ❑ |
| 46. often exhausted or fatigued _____ | ❑ | ❑ |
| 47. subject to frequent headaches _____ | ❑ | ❑ |
| 48. a smoker or smoked previously _____ | ❑ | ❑ |
| 49. often unhappy or depressed _____ | ❑ | ❑ |
| 50. FEMALE - taking birth control pills _____ | ❑ | ❑ |
| 51. FEMALE - pregnant _____ | ❑ | ❑ |
| 52. 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

| 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:** **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? _____ ❑ ❑

## 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, becoming shorter, thinner or worn? _____ ❑ ❑
15. Are you 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 last 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 _____