MEDICAL HISTORY

Patient Name _____ Age _____

Name of Physician _____

Most recent physical examination _____ Purpose _____

What is you 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	☐	☐
Penicillin	☐	☐
Tetracycline	☐	☐
Codeine	☐	☐
Local anesthetic	☐	☐
Flounder	☐	☐
Metals (nickel, gold, silver, _____)	☐	☐
Latex	☐	☐
Other:	☐	☐
3. Heart problems, or cardiac stent within six months	☐	☐
4. History of infective endocarditic	☐	☐
5. Artificial heart valve, repaired heart defect (PFO)	☐	☐
6. Pacemaker or implantable defibrillator	☐	☐
7. Artificial or implantable defibrillator	☐	☐
8. Artificial prosthesis (heart valve or joints)	☐	☐
9. Rheumatic or scarlet fever	☐	☐
10. High or low blood pressure	☐	☐
11. A stroke (taking blood thinners)	☐	☐
12. Anemia or other blood disorder	☐	☐
13. Prolonged bleeding due to slight cut (INR 3.5)	☐	☐
14. Emphysema, sarcoidosis	☐	☐
15. Tuberculosis	☐	☐
16. Asthma	☐	☐
17. Breathing or sleep problems (Snoring, sinus)	☐	☐
18. Kidney disease	☐	☐
19. Liver disease	☐	☐
20. Jaundice	☐	☐
21. Thyroid, parathyroid disease, or calcium deficiency	☐	☐
22. Hormone deficiency	☐	☐
23. High cholesterol or taking statin drugs	☐	☐
24. Diabetes (HbA1c=_____)	☐	☐
25. Stomach or Duodenal ulcer	☐	☐
26. Osteoporosis/osteopenia (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 infection and cold sores	☐	☐
34. Any lumps or swelling in the mouth	☐	☐
35. Hives, skin rash, hay fever	☐	☐
36. STI/STD	☐	☐
37. Hepatitis (Type A_____)	☐	☐
38. HIV/AIDS	☐	☐
39. Tumor, abnormal growth	☐	☐
40. Radiation therapy	☐	☐
41. Chemotherapy	☐	☐
42. Emotional problems	☐	☐
43. Psychiatric problems	☐	☐
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 (Fever, new cough)	☐	☐
48. Taking medication for weight management	☐	☐
49. Taking dietary supplements	☐	☐
50. Often exhausted or fatigued	☐	☐
51. Experiencing frequent headaches	☐	☐
52. A smoker, 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	☐	☐

List all medications, supplements, and or vitamins taken within the last two years:

_____

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? _____

Date of most recent dental exam? _____ Date of most recent x-rays: _____ I routinely see my dentist every: _____

WHAT IS YOUR IMMEDIATE CONCERN? : _____

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	**YES**	**NO**
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 of self conscious about the appearance of your teeth?	☐	☐
10. Have you been disappointed with the appearance of previous dental work?	☐	☐
BITE AND JAW JOINT	**YES**	**NO**
11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
12. Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
13. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
14. Have your teeth changed in the last 5 years, become shorter, thinner?	☐	☐
15. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
16. Are your teeth developing space or becoming looser?	☐	☐
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; wake up with a headache or an awareness of your teeth?	☐	☐
20. Do you or have you ever worn a bite appliance?	☐	☐
TOOTH STRUCTURE	**YES**	**NO**
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 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 frequently get food caught between any teeth?	☐	☐
GUM AND BONE	**YES**	**NO**
28. Do your gums bleed or are they painful 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