



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

Antibiotic PRE-MED: Do you require antibiotics prior to dental treatment? Yes No

DO YOU HAVE or HAVE YOU EVER HAD:

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. hospitalization for illness or injury _____ | <input type="checkbox"/> | <input type="checkbox"/> | 21. osteoporosis / osteopenia _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic reaction to _____ | | | 22. history of bisphosphonate use (Actonel®, Boniva®, Fosamax®, Aredia®, Zometa®, etc.) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine | | | 23. arthritis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin _____ | | | 24. glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other antibiotics _____ | | | 25. head or neck injuries _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic _____ | | | 26. epilepsy, convulsions _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (nickel, gold, silver) _____ | | | 27. viral infections and cold sores _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex _____ | | | 28. any lumps or swelling in the mouth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | | | 29. hepatitis (type _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last 6 months _____ | <input type="checkbox"/> | <input type="checkbox"/> | 30. HIV / AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 31. tumor / abnormal growth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect _____ | <input type="checkbox"/> | <input type="checkbox"/> | 32. radiation therapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____ | <input type="checkbox"/> | <input type="checkbox"/> | 33. chemotherapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. artificial prosthesis (heart valve or joints) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 34. psychiatric treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. high or low blood pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | 35. antidepressant medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. a stroke _____ | <input type="checkbox"/> | <input type="checkbox"/> | 36. alcohol abuse / addiction _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. anemia or other blood disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> | 37. street drug abuse / addiction _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. prolonged bleeding due to a slight cut (INR >3.5) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 12. Coumadin / Warfarin Use _____ | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| 13. tuberculosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 38. presently being treated for any other illness _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> | 39. aware of a change in your health (i.e. fever, new cough) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. breathing or sleep problems (i.e. snoring, sinus) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 40. often exhausted or fatigued _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. kidney disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 41. experiencing frequent headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. liver disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 42. a smoker, smoked previously or use smokeless tobacco _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. thyroid, parathyroid disease, or calcium deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 43. often unhappy or depressed _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. diabetes _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. FEMALE - pregnant / nursing _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. digestive disorders (i.e. heartburn or gastric reflux) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Describe any medical treatment, impending surgery, genetic / developmental anomalies, or other medical concerns that may possibly affect your dental treatment.

List all current medication and dosages. (Including aspirin, birth control pills, vitamins, herbal supplements, blood thinners, etc.)

Drug	Dose	Drug	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for 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



Name _____ Age _____

How would you rate your mouth? Excellent Good Poor

Previous Dentist _____

Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date of most recent treatment (other than cleaning) ____/____/____

I routinely see my dentist every: 3 mo. 4 mo. 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? How fearful on a scale of 1(least) to 10(most) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or have your bite adjusted? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Smile Characteristics

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

Bite and Jaw Joint

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

Tooth Structure

- | | | |
|---|--------------------------|--------------------------|
| 20. Have you had any cavities within the past 3 years? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have a dry mouth or difficulty swallowing food? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are any teeth sensitive to hot, cold, biting or sweets? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever broken teeth, chipped teeth. or had a toothache or cracked filling? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you frequently get food caught between any teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Gum and Bone

- | | | |
|--|--------------------------|--------------------------|
| 25. Do your gums bleed or are they painful when brushing any part of your mouth or flossing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you ever noticed an unpleasant taste or odor in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Is there anyone with a history of periodontal disease in your family? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you experienced gum recession? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you experienced a burning sensation in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____