

MEDICAL HISTORY

Patient Name _____ Email _____ Age _____

Name of physician and 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		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (ie taking bisphosphonates)___	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to _____	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			28. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			29. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulpha			32. neurologic problems (attention deficit disorder) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			33. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			35. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			37. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent in last six months ___	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) ___	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7. artificial prosthesis (heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol / drug dependency _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>			
12. prolonged bleeding due to a slight cut (INR > 3.5) ___	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
13. emphysema, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	46. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47. aware of a change in your general health _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	48. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. snoring, sinus) ___	<input type="checkbox"/>	<input type="checkbox"/>	49. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51. subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	52. a smoker or smoked previously _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency ___	<input type="checkbox"/>	<input type="checkbox"/>	53. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54. FEMALE – taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	55. FEMALE – pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c = _____)	<input type="checkbox"/>	<input type="checkbox"/>	56. MALE – prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			
25. digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			

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

<u>Drug</u>	<u>Purpose</u>	<u>Drug</u>	<u>Purpose</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.

Patients's Signature _____ Date _____

Doctor's Signature _____ Date _____



DENTAL HISTORY

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? _____

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 do you 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 or do you have difficulty eating an apple? _____
34. Have you experienced a burning sensation in your mouth? _____

Patients's Signature _____ Date _____

Doctor's Signature _____ Date _____