

# 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

**HAVE YOU EVER HAD THE FOLLOWING:**

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	25. digestive disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
2. allergic reaction to _____			26. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen			27. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			28. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			29. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			30. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> codeine			31. neurologic problems _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			32. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			33. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (gold, stainless steel)			34. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			35. venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> any other medications _____			36. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems _____	<input type="checkbox"/>	<input type="checkbox"/>	37. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>	38. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>	39. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	40. chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7. high blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	41. emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8. low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	42. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. a stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	43. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. artificial prosthesis (i.e. heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	44. 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 _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>ARE YOU:</b>		
13. emphysema _____	<input type="checkbox"/>	<input type="checkbox"/>	45. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	46. aware of a change in your general health _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	47. taking medication for osteoporosis/osteopenia _____	<input type="checkbox"/>	<input type="checkbox"/>
16. sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>	48. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	49. subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50. a smoker or smoked previously _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	51. considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid or parathyroid disease _____	<input type="checkbox"/>	<input type="checkbox"/>	52. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	53. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol _____	<input type="checkbox"/>	<input type="checkbox"/>	54. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	55. MALE - Prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			

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 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? Scale of 1 to 10 (very) \_\_\_\_\_  YES  NO
2. Have you had an unfavorable dental experience? \_\_\_\_\_  YES  NO
3. Have you ever had complications from past dental treatment? \_\_\_\_\_  YES  NO
4. Have you ever had trouble getting numb or reactions to local anesthetic? \_\_\_\_\_  YES  NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? \_\_\_\_\_  YES  NO
6. Have you had any teeth removed? \_\_\_\_\_  YES  NO

## SMILE CHARACTERISTICS



7. Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_  YES  NO
8. Have you ever whitened (bleached) your teeth? \_\_\_\_\_  YES  NO
9. Are you self conscious about your teeth? \_\_\_\_\_  YES  NO
10. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_  YES  NO

## BITE AND JAW JOINT



11. Do you / would you have any problems chewing gum? \_\_\_\_\_  YES  NO
12. Do you / would you have any problems chewing bagels or other hard foods? \_\_\_\_\_  YES  NO
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_  YES  NO
14. Are your teeth crowding or developing spaces? \_\_\_\_\_  YES  NO
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? \_\_\_\_\_  YES  NO
16. Do you have any problems with sleep or wake up with an awareness of your teeth? \_\_\_\_\_  YES  NO
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_  YES  NO
18. Do you have tension headaches or sore teeth? \_\_\_\_\_  YES  NO
19. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_  YES  NO

## TOOTH STRUCTURE



20. Have you had any cavities within the past 3 years? \_\_\_\_\_  YES  NO
21. Do you have a dry mouth? \_\_\_\_\_  YES  NO
22. Are any teeth sensitive to hot, cold, biting or sweets? \_\_\_\_\_  YES  NO
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? \_\_\_\_\_  YES  NO
24. Do you avoid brushing any part of your mouth? \_\_\_\_\_  YES  NO

## GUM AND BONE



25. Have you ever been diagnosed or treated for periodontal (gum) disease? \_\_\_\_\_  YES  NO
26. Have you ever experienced gum recession? \_\_\_\_\_  YES  NO
27. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_  YES  NO
28. Do your gums bleed when brushing, flossing or eating? \_\_\_\_\_  YES  NO
29. Are your teeth becoming loose? \_\_\_\_\_  YES  NO
30. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_  YES  NO
31. Have you experienced a burning sensation in your mouth? \_\_\_\_\_  YES  NO

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_