

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
25. Do you feel or notice any holes (i.e. pitting) in your teeth? _____ YES NO

GUM AND BONE



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

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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

DO YOU HAVE or HAVE YOU EVER HAD:

YES NO

YES NO

1. hospitalization for illness or injury _____
2. an allergic reaction to
 - aspirin, ibuprofen, acetaminophen
 - penicillin
 - erythromycin
 - tetracycline
 - codeine
 - local anesthetic
 - fluoride
 - metals (gold, stainless steel)
 - latex
 - any other medications _____
3. heart problems _____
4. heart murmur _____
5. rheumatic fever _____
6. scarlet fever _____
7. high blood pressure _____
8. low blood pressure _____
9. a stroke _____
10. artificial prosthesis (i.e. heart valve or joints) _____
11. anemia or other blood disorder _____
12. prolonged bleeding due to a slight cut _____
13. emphysema _____
14. tuberculosis _____
15. asthma _____
16. breathing or sleep problems (i.e. snoring, sinus) _____
17. kidney disease _____
18. liver disease _____
19. jaundice _____
20. thyroid or parathyroid disease _____
21. hormone deficiency _____
22. high cholesterol _____
23. diabetes _____
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. neurologic problems _____
33. viral infections and cold sores _____
34. any lumps or swelling in the mouth _____
35. hives, skin rash, hay fever _____
36. venereal disease _____
37. hepatitis (type _____) _____
38. HIV / AIDS _____
39. tumor, abnormal growth _____
40. radiation therapy _____
41. chemotherapy _____
42. emotional problems _____
43. psychiatric treatment _____
44. antidepressant medication _____
45. alcohol / drug dependency _____

ARE YOU:

46. presently being treated for any other illness _____
47. aware of a change in your general health _____
48. taking medication for weight management (i.e. fen-phen) _____
49. taking dietary supplements _____
50. often exhausted or fatigued _____
51. subject to frequent headaches _____
52. a smoker or 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 _____

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

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 _____