Medical History

Date: _____

Patient name_____Nickname_____ Age_____

Name of Physician/and their specialty_____

Most recent physical examination_____Purpose_____

What is the estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE OR HAVE YOU EVER HAD: **YES** **NO**

1. Need to pre-medicate for dental procedures _____
2. Hospitalization for illness injury_____
3. Heart problems, chest pains or cardiac stent within the last 6 months_____
4. Heart murmur_____
5. History of infective endocarditis _____
6. Artificial heart valve, repaired heart defect_____
7. Pacemaker or implantable defibrillator_____
8. Orthopedic implant(joint replacement)_____
9. Rheumatic or scarlet fever_____
10. High or low blood pressure_____
11. A stroke (taking blood thinners)_____
12. Anemia/blood disorder transfusion_____
13. Prolonged bleeding due to a slight cut_____
14. Problems with bruising easily _____
15. Emphysema, shortness of breath, sarcoidosis_____
16. Tuberculosis, measles, chicken pox_____
17. Asthma_____
18. Breathing, sleep problems (i.e sleep apnea, snoring, sinus) _____
19. Kidney disease _____
20. Liver disease_____
21. Jaundice_____
22. Thyroid, parathyroid disease, or calcium deficiency_____
23. Hormone deficiency/problems_____
24. Excessive urination or thirst_____
25. High cholesterol or taking satin drugs_____
26. Diabetes _____
27. Stomach or duodenal ulcer _____
28. Digestive disorders (i.e celiac disease, gastric reflux) _____
29. Osteoporosis/osteopenia (i.e. taking bisphosphonates)_____ If so, oral/IV_____When?_____
30. An allergic reaction to_____ Aspirin, ibuprofen, acetaminophen, codeine_____ Penicillin _____ Erythromycin_____ Tetracycline_____ Sulfa_____ Local anesthetic_____ Fluoride_____ Metals(nickel, gold, silver, _____) Latex_____
31. Head or neck injuries_____
32. Enlarged lymph nodes_____
33. Epilepsy, convulsions(seizures)_____
34. Neurological disorders (ADD/ADHD)_____
35. Viral infections and cold sores_____
36. Any lumps or swelling in the mouth_____
37. Hives, skin rash, hay fever_____
38. STI/STD/HPV_____
39. Hepatitis(type_____)_____
40. HIV/AIDS_____
41. Cancer _____
42. Tumor, abnormal growth_____
43. Radiation therapy_____
44. Chemotherapy, immunosuppressive med._____
45. Emotional difficulties_____
46. Psychiatric treatment_____
47. Antidepressant medication_____
48. Alcohol/recreational drug use_____
49. Arthritis_____
50. Autoimmune disease_____
51. Glaucoma_____
52. Contact lenses_____
53. Genetic problem(s)_____

ARE YOU:

54. Presently being treated for any other illness_____ _____
55. Aware of a change in your health in the last 24 hours (i.e. fever, chills, or diarrhea)_____
49. Taking medication for weight management_____
50. Taking dietary supplements_____
51. Often exhausted or fatigued_____
52. Experiencing frequent headaches_____
53. A smoker, smoked previously or use smokeless tobacco_____
54. Considered a touchy/sensitive person_____
55. Often unhappy or depressed_____
56. Taking birth control pills_____
57. Currently pregnant_____
58. Prostate disorders _____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen injections)

_____
_____
_____
_____
_____

List all medications, supplements, and or vitamins taking now or within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OF MEDICATIONS.

Dental History

Date:_____

Referred by_____How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist_____How long have you been a patient?_____

Last dental exam_____/_____/_____ Last full mouth x-rays_____/_____/_____ Last dental cleaning _____/_____/_____

Most recent treatment (other than a cleaning)_____/_____/_____

I routinely see my dentist every: 3mo. 4mo. 6mo. 12months not routinely

Type of toothbrush I use to brush to my teeth: manual electric How often do you floss? _____

What is your immediate concern?_____

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING.

PERSONAL HISTORY

1. Are you fearful of dental treatment?_____ If yes, 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 treatments?_____
4. Have you ever had trouble getting numb or had reactions to local anesthetic?_____
5. Have you had a serious injury to the mouth or head?_____

GUMS AND BONE

7. Do your gums bleed or are they painful when brushing or flossing?_____
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?_____
9. Have you ever noticed an unpleasant taste or odor in your mouth?_____
10. Is there anyone with a history of periodontal disease in your family?_____
11. Have you ever experienced gum recession?_____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating?_____
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?_____
14. Do you smoke or chew tobacco?_____

TOOTH STRUCTURE

15. Have you had any cavities within the past 3 years?_____
16. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?_____
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?_____
18. Do you have grooves or notches on your teeth near the gum line?_____
19. Do you frequently get food caught between any teeth?_____

BITE AND JAW JOINT

20. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping?_____
21. Did you ever have braces, orthodontic treatment, or your bite adjusted?_____
22. Do you avoid or have difficulty chewing hard and dry foods?_____
23. Have your teeth changed in the last 5 years, become shorter, thinner or worn?_____
24. Are your teeth becoming more crooked, crowded, or overlapped?_____
25. Are your teeth developing spaces or becoming looser?_____
26. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?_____
27. Do you chew ice, bite your nails, use your teeth to hold foreign objects or have any other oral habits?_____
28. Do you clench your teeth in the daytime/ nighttime or make them sore?_____
29. Do you have any problems with sleep (i.e. restlessness),wake up with a headache or an awareness of your teeth?_____
30. Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change?_____
32. Have you ever whitened (bleached) your teeth?)? _____
33. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____
34. Have you been disappointed with the appearance of previous dental work?_____

Patient's Signature_____ Date_____

CONFIDENTAL INFORMATION

First Name	Last Name	MI	DOB	Sex
Home Phone #	Cell Phone #		Social Security Number	
Home Address	Apt. #	City	State	Zip	E-mail
Marital Status : (Circle one)	Single	Married	Widowed	Divorced	Other
Patient's/Guardian's Employer			Occupation	
Work Address	City	State	Zip	Work Phone #
Spouse's First Name	Last Name	MI	Spouse's Employer	Occupation
Other family members that are patients here		Who can we thank for referring you to our office?		

EMERGENCY CONTACT INFORMATION

PLEASE NAME A PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY

Name		Relationship
Home Phone #	Work Phone #	Cell Phone #

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

Contact me at home	YES	NO
Contact me via cell phone	YES	NO
Contact me at work	YES	NO
Contact me via e-mail	YES	NO

CONSENT: The undersigned herby authorized the doctor to perform all necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

Person financially responsible for account _____

Patient Signature _____

Signature of parent of child_____