Dental History

Patient Name_____ Age _____ Date _____

Reason for seeking care today: ___ Exam ___ Cleaning ___ Specific Problem _____ (Please describe)

Please check all that apply:

- ☐ Toothache
- ☐ Broken filling or tooth
- Sensitivity to:
  - ☐ Cold
  - ☐ Hot
  - ☐ Sweets
  - ☐ Chewing
- ☐ Food catches
- ☐ Loose teeth
- ☐ Floss breaks easily or hurts
- ☐ Bite or teeth have shifted
- ☐ Often bite cheeks
- ☐ Frequent dry mouth
- ☐ Concerned about breath
- ☐ Unhappy with previous dental work
- ☐ Gums bleed
- ☐ Gums tender
- ☐ Growths, sores
- ☐ Cold sores, fever blisters
- ☐ Cracked, chapped lips
- ☐ Bad taste in mouth
- ☐ Sinus problems
- ☐ Mouth breathe – Difficulty breathing through nose
- ☐ Dry or strained eyes
- ☐ Shoulder, neck or headaches
- ☐ Clench or grind teeth
- ☐ Jaw joint pain
- ☐ Clicking or popping of joint.
- ☐ Unable to open mouth wide
- ☐ Jaw gets tired easily.
- ☐ Hold things between teeth (Pipe, pencil, nails, pins)
- ☐ Bite fingernails
- ☐ Unusual habits with teeth
- ☐ Wore braces
- ☐ Previous gum treatment
- ☐ Previous bite treatment

Would you like whiter teeth? _____ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?

_____

Please rate 1-10 how anxious you are about dental treatment (1= totally relaxed) _____

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____

Why did you leave your previous dentist?_____

Did your parents have difficulties with their teeth or dental treatments?_____

Medical History

Physicians Name:_____

City: _____ Phone _____

Have you been hospitalized for any reason? Please describe:

_____

_____

Are you taking any medications or drugs (including nutritional supplements?) Please list: (Continue on back of form if needed)

_____

_____

Are you taking or have ever taken Bisphosphonates? If yes, name of drug and how long taken. _____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, jewelry, metal, tetrocycline, food allergies, other? _____

_____

Do you smoke? How much/day? _____

Pregnant? Due date _____ Are you nursing? _____

Are you seeing a physician now or planning to see one for any reason? Please explain: (Continue on back of form if needed)

_____

_____

_____

_____

Please check all that apply:

- ☐ Previous injury to head or neck
- ☐ Heart problem
- ☐ Heart Attack
- ☐ Angina, chest pain
- ☐ Heart murmur
- ☐ Scarlet, Rheumatic fever
- ☐ Mitral valve prolapse
- ☐ Irregular heartbeat
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Artificial joint, bones, valves
- ☐ Neurological disorders
- ☐ Depression
- ☐ T8
- ☐ Diabetes
- ☐ HIV or AIDS
- ☐ Kidney problem
- ☐ Liver problem, jaundice
- ☐ Cirrhosis, Hepatitis
- ☐ Cancer, Radiation, Chemotherapy
- ☐ Respiratory problem
- ☐ Bloody, persistent cough
- ☐ Asthma, Emphysema
- ☐ Anemia
- ☐ Sickle cell disease
- ☐ Osteoporosis (list meds)

_____

- ☐ Psychotic problems
- ☐ STD
- ☐ Digestive problem, ulcer
- ☐ Thyroid disease
- ☐ Glaucoma
- ☐ Bleed or bruise easily
- ☐ Stroke
- ☐ Epilepsy or Seizures
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ Back problem
- ☐ Hives, rash
- ☐ Dry eyes
- ☐ Colitis
- ☐ Sinus Problems
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Snoring, sleep apnea
- ☐ No energy
- ☐ Fainting or dizzy
- ☐ Unexplained weight loss
- ☐ Chewing tobacco
- ☐ Drug or alcohol addiction
- ☐ 2 or more social drinks/day
- ☐ Anxiety or nervous disorder
- ☐ Insomnia
- ☐ Contact lenses
- ☐ Herpes/Fever Blsiters

Any other illnesses not checked above?_____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: ☐ Yes ☐ No

Please rate the following indicators of your daily stress level: 1-10 : (1 = low, 10 = high)

____Overworked, too busy, pressured ____ Feel frustrated ____ Get upset or "snap" easily ____Depression, anxiety

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian) _____ Date_____

Dentist' Signature_____ Date_____