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
1. hospitalization for illness or injury _____	○	○
2. an allergic or bad reaction to any of the following:	○	○
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex _____		
☐ nuts _____		
☐ fruit _____		
☐ milk _____		
☐ red dye _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months _____	○	○
4. history of infective endocarditis _____	○	○
5. artificial heart valve, repaired heart defect (PFO) _____	○	○
6. pacemaker or implantable defibrillator _____	○	○
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) _	○	○
8. heart murmur, rheumatic or scarlet fever _____	○	○
9. high or low blood pressure _____	○	○
10. a stroke (taking blood thinners) _____	○	○
11. anemia or other blood disorder _____	○	○
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	○	○
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	○	○
14. chronic ear infections, tuberculosis, measles, chicken pox _____	○	○
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	○	○
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _	○	○
17. kidney disease _____	○	○
18. liver disease or jaundice _____	○	○
19. vertigo (e.g. "the room is spinning") _____	○	○
20. thyroid, parathyroid disease, or calcium deficiency _____	○	○
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) _____	○	○
22. high cholesterol or taking statin drugs _____	○	○
23. diabetes (HbA1c=_____) _____	○	○
24. stomach or duodenal ulcer _____	○	○
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	○	○

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	○	○
27. arthritis or gout _____	○	○
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	○	○
29. glaucoma _____	○	○
30. contact lenses _____	○	○
31. head or neck injuries _____	○	○
32. epilepsy, convulsions (seizures) _____	○	○
33. neurologic disorders (ADD/ADHD, prion disease) _____	○	○
34. viral infections and cold sores _____	○	○
35. any lumps or swelling in the mouth _____	○	○
36. hives, skin rash, hay fever _____	○	○
37. STI/STD/HPV _____	○	○
38. hepatitis (type____) _____	○	○
39. HIV/AIDS _____	○	○
40. tumor, abnormal growth _____	○	○
41. radiation therapy _____	○	○
42. chemotherapy, immunosuppressive medication _____	○	○
43. emotional difficulties _____	○	○
44. psychiatric treatment or antidepressant medication _____	○	○
45. concentration problems or ADD/ADHD diagnosis _____	○	○
46. alcohol/recreational drug use _____	○	○
47. speech difficulties or delayed growth at any time _____	○	○
ARE YOU:		
48. presently being treated for any other illness _____	○	○
49. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	○	○
50. taking medication for weight management _____	○	○
51. taking dietary supplements _____	○	○
52. often exhausted or fatigued _____	○	○
53. experiencing frequent headaches or chronic pain _____	○	○
54. a smoker, smoked previously or use smokeless tobacco _____	○	○
55. considered a touchy/sensitive person _____	○	○
56. often unhappy or depressed _____	○	○
57. taking birth control pills _____	○	○
58. currently pregnant _____	○	○
59. diagnosed with a prostate disorder _____	○	○

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 taken within the last two years

Drug	Purpose	Drug	Purpose

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 _____

ASA _____ **(1-6)**

DENTAL HISTORY

Patient Name_____ Nickname_____ Age_____

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

TOOTH STRUCTURE	**YES**	**NO**
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT	**YES**	**NO**
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS	**YES**	**NO**
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever whitened (bleached) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature_____ Date _____

Doctor's Signature_____ Date _____

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