

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 _____	<input type="checkbox"/>	<input type="checkbox"/>	26.	osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	an allergic or bad reaction to any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	27.	arthritis or gout _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			28.	autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> penicillin			29.	glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> erythromycin			30.	contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> tetracycline			31.	head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> sulfa			32.	epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> local anesthetic			33.	neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> fluoride			34.	viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> chlorhexidine (CHX)			35.	any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> metals (nickel, gold, silver, _____)			36.	hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> latex _____			37.	STI/STD/HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> nuts _____			38.	hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> fruit _____			39.	HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> milk _____			40.	tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> red dye _____			41.	radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> other _____			42.	chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
3.	heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	43.	emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
4.	history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	44.	psychiatric treatment or antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
5.	artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	45.	concentration problems or ADD/ADHD diagnosis _____	<input type="checkbox"/>	<input type="checkbox"/>
6.	pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	46.	alcohol/recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
7.	orthopedic or soft tissue implant (e.g. joint replacement, breast implant) _____	<input type="checkbox"/>	<input type="checkbox"/>	47.	speech difficulties or delayed growth at any time _____	<input type="checkbox"/>	<input type="checkbox"/>
8.	heart murmur, rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>				
9.	high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:			
10.	a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	48.	presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
11.	anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	49.	aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
12.	prolonged bleeding due to a slight cut (or INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	50.	taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
13.	pneumonia, emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	51.	taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
14.	chronic ear infections, tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	52.	often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
15.	breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	<input type="checkbox"/>	<input type="checkbox"/>	53.	experiencing frequent headaches or chronic pain _____	<input type="checkbox"/>	<input type="checkbox"/>
16.	sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____	<input type="checkbox"/>	<input type="checkbox"/>	54.	a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
17.	kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	55.	considered a touchy/sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
18.	liver disease or jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	56.	often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
19.	vertigo (e.g. "the room is spinning") _____	<input type="checkbox"/>	<input type="checkbox"/>	57.	taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
20.	thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	58.	currently pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
21.	hormone deficiency or imbalance (e.g. polycystic ovarian syndrome) _____	<input type="checkbox"/>	<input type="checkbox"/>	59.	diagnosed with a prostate disorder _____	<input type="checkbox"/>	<input type="checkbox"/>
22.	high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>				
23.	diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>				
24.	stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>				
25.	digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	<input type="checkbox"/>	<input type="checkbox"/>				

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 _____

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

TOOTH STRUCTURE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	YES	NO
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have grooves or notches on your teeth near the gum line? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you frequently get food caught between any teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BITE AND JAW JOINT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Are your teeth developing spaces or becoming more loose? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you clench or grind your teeth together in the daytime or make them sore? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Do you wear or have you ever worn a bite appliance? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SMILE CHARACTERISTICS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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)? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you ever whitened (bleached) your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Have you been disappointed with the appearance of previous dental work? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____