Medical Health History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Physician's Name: _____ Date of Last Physical: _____ Phone: _____

Have you ever been hospitalized or had a major operation? _____

Have you ever had a serious head or neck injury? _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? _____

Do you use tobacco? _____

Do you use controlled substances? _____

Please check the box of any conditions you have or have had.

Allergies ☐ None

☐ Acetaminophen	☐ Codeine	☐ Local anesthetic	☐ Other_____
☐ Aspirin	☐ Erythromycin	☐ Metals	_____
☐ Barbituates/sedatives	☐ Ibuprofen	☐ Penicillin	
☐ Cephalosporins	☐ Latex	☐ Sulfa	

Health Issues

☐ Anaphylaxis	☐ Cold Sores/Fever Blisters	☐ Heart Pacemaker	☐ Radiation Treatment
☐ Anemia/Sickle Cell	☐ Congenital Heart Defect	☐ High Blood Pressure	☐ Respiratory Disease/COPD
☐ Angina	☐ Congestive Heart Failure	☐ High Cholesterol	☐ Rheumatic Fever
☐ Arthritis/Gout	☐ Diabetes	☐ HIV/AIDS	☐ Sinus Problems
☐ Artificial Heart Valve	☐ Dizziness/Fainting	☐ Infective Endocarditis	☐ Stroke
☐ Artificial Joint	☐ Eating Disorder	☐ Jaundice	☐ Thyroid
☐ Asthma	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Tuberculosis
☐ Breathing/Sleep Issues	☐ Frequent Headaches	☐ Hepatitis	☐ Tumors
☐ Bruise Easily	☐ Glaucoma	☐ Mental Disorder	☐ Ulcers/GERD
☐ Cancer	☐ Heart Attack	☐ Organ Transplant	☐ Other
☐ Chemotherapy	☐ Heart Murmur	☐ Osteoporosis	

Medications

List all medications, supplements, and vitamins

_____		_____
_____		_____
_____		_____
_____		_____

Patient Signature _____ Date _____

Dental History Form

Patient Name: _____ Age _____

Date of most recent dental exam _____/_____/_____ I see my Dentist (circle): 3 M 6 M 12 M Not Routinely

What is your immediate concern? _____

On a scale of 1-10 (10 greatest), how important is your dental health? **1 2 3 4 5 6 7 8 9 10**

On a scale of 1-10 (10 greatest), how would you rate your current dental health? **1 2 3 4 5 6 7 8 9 10**

On a scale of 1-10 (10 greatest), how fearful are you of dental treatment? **1 2 3 4 5 6 7 8 9 10**

Personal History	**Yes**	**No**
1. Have you had an unfavorable dental experience?	☐	☐
2. Have you ever had complications from past dental treatment?	☐	☐
3. Have you ever had trouble getting numb or had any reactions to local anesthesia?	☐	☐
4. Do you have, or have you had, any teeth removed or teeth that never developed?	☐	☐
5. Did you ever have orthodontic treatment, braces, or your bite adjusted?	☐	☐
Gum/Bone History- Periodontal	**Yes**	**No**
6. Do your gums bleed or do they hurt during brushing/flossing?	☐	☐
7. Have you ever been told you have gum disease or are losing bone around your teeth?	☐	☐
8. Have you ever noticed an unpleasant taste/smell in your mouth?	☐	☐
9. Does anyone in your family have a history of periodontal/gum disease?	☐	☐
10. Have you experienced gum recession (teeth look longer)?	☐	☐
11. Have you ever had any teeth becomes loose on their own?	☐	☐
Tooth Structure History- Cavities	**Yes**	**No**
12. Have you had any cavities within the past 3 years?	☐	☐
13. Does the amount of saliva in your mouth seem to little or do you have trouble eating/swallowing food?	☐	☐
14. Do you feel or notice any holes on the tops of your teeth?	☐	☐
15. Are your teeth sensitive to hot, cold, or sweets or do you avoid brushing any area?	☐	☐
16. Do you have grooves or notches on your teeth near the gumline?	☐	☐
17. Have you ever broken, chipped, or cracked any teeth or had a toothache?	☐	☐
18. Do you get food caught between your teeth?	☐	☐
Occlusion History- Bite, Jaw & TMJ	**Yes**	**No**
19. Do you have problems with your jaw joint? (pain, popping, cracking, locking)	☐	☐
20. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
21. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
22. Are your teeth developing spaces or becoming loose?	☐	☐
23. Do you clench your teeth during the day or night or wake with a headache?	☐	☐
24. Do you wear, or have you ever worn, a bite appliance?	☐	☐
Cosmetic History- Smile	**Yes**	**No**
25. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
26. Have you ever whitened/bleached your teeth?	☐	☐
27. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
28. Have you been disappointed with the appearance of previous dental work?	☐	☐