# DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

**WHAT IS YOUR IMMEDIATE CONCERN?** _____

## PLEASE ANSWER YES OR NO TO THE FOLLOWING:

| | | YES | NO |
|---|---|---|---|
| **PERSONAL HISTORY** | | | |
| 1. | Are you fearful of dental treatment? 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 treatment? | ☐ | ☐ |
| 4. | Have you ever had trouble getting numb or had any reactions to local anesthetic? | ☐ | ☐ |
| 5. | Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? | ☐ | ☐ |
| 6. | Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? | ☐ | ☐ |
| **GUM AND BONE** | | | |
| 7. | Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? | ☐ | ☐ |
| 8. | Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? | ☐ | ☐ |
| 9. | Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? | ☐ | ☐ |
| 10. | Is there anyone with a history of periodontal disease in your family? | ☐ | ☐ |
| 11. | Have you ever experienced gum recession, or can you see more of the roots of your teeth? | ☐ | ☐ |
| 12. | Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? | ☐ | ☐ |
| 13. | Have you experienced a burning, painful sensation, or metallic taste in your mouth? | ☐ | ☐ |
| **TOOTH STRUCTURE** | | | |
| 14. | Have you had any cavities within the past 3 years? | ☐ | ☐ |
| 15. | Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing 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** | | | |
| 21. | Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking? | ☐ | ☐ |
| 22. | Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together? | ☐ | ☐ |
| 23. | Do you avoid or have difficulty chewing gum, raw 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 more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? | ☐ | ☐ |
| 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 / nighttime or ever 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** | | | |
| 33. | Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)? | ☐ | ☐ |
| 34. | Have you ever bleached (whitened) 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 _____

# 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) _____ | | |
| ○ Iodine _____ | | |
| ○ 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., polycystic ovarian syndrome) ____ | ☐ | ☐ |
| 22. high cholesterol or taking statin drugs _____ | ☐ | ☐ |
| 23. diabetes (HbA1c = _____ ) _____ | ☐ | ☐ |
| 24. stomach or duodenal ulcer _____ | ☐ | ☐ |
| 25. digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease)_____ | ☐ | ☐ |

| | 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 (e.g., Alzheimer's disease, dementia, prion disease)_ | ☐ | ☐ |
| 34. viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease)__ | ☐ | ☐ |
| 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. difficulties with stress management _____ | ☐ | ☐ |
| 44. psychiatric treatment, antidepressants, mood stabilizing medications | ☐ | ☐ |
| 45. concentration problems or ADD/ADHD _____ | ☐ | ☐ |
| 46. alcohol/recreational drug use _____ | ☐ | ☐ |
| **ARE YOU:** | | |
| 47. presently being treated for any other illness _____ | ☐ | ☐ |
| 48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____ | ☐ | ☐ |
| 49. taking medication for weight management _____ | ☐ | ☐ |
| 50. taking dietary supplements, vitamins, and/or probiotics _____ | ☐ | ☐ |
| 51. often exhausted or fatigued _____ | ☐ | ☐ |
| 52. experiencing frequent headaches or chronic pain _____ | ☐ | ☐ |
| 53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) _____ | ☐ | ☐ |
| 54. considered a touchy/sensitive person _____ | ☐ | ☐ |
| 55. often unhappy or depressed _____ | ☐ | ☐ |
| 56. taking birth control pills _____ | ☐ | ☐ |
| 57. currently pregnant _____ | ☐ | ☐ |
| 58. 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, vitamins, and/or probiotics 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)**