DENTAL HISTORY

Referred by_____ Today's Date_____

Previous Dentist_____ How long_____

Most Recent Dental Exam_____ Most Recent Dental X-ray_____

Most Recent Dental Treatment_____

How often do you have your teeth cleaned? 3mo____ 4mo____ 6mo____ 1year or longer ____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
Are you unhappy with the appearance of your teeth?	☐	☐
Do your gums bleed when you brush?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Do you have earaches or neck pains?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Do you wear removable dental appliances?	☐	☐
Have you had an unfavorable dental experience?	☐	☐
Do you have any dental fears?	☐	☐
Do you have trouble getting numb?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Do you have dry mouth, throat or eyes?	☐	☐
Do you have jaw problems (temporomandibular joint)?	☐	☐
Do you have difficulty opening your mouth widely?	☐	☐
Do you have stiff neck muscles?	☐	☐
Do you awaken with an awareness of your teeth or jaws?	☐	☐
Do you have tension headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Does your jaw click or pop?	☐	☐
Have you lost any teeth?	☐	☐

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES	NO	(Please check Yes or No)
☐	☐	Has your present denture been relined? When_____
☐	☐	Is your present denture a problem? Describe_____
☐	☐	Satisfied with the appearance? _____
☐	☐	Satisfied with the comfort? _____
☐	☐	Satisfied with the chewing ability? _____
☐	☐	When did you receive your first partial or complete denture? _____
☐	☐	How long have you worn your present denture? _____

Patient's Signature _____ Date _____

Doctor's Signature _____

MEDICAL HISTORY

Patient Name _____Nickname _____ Age _____

Name of Physician_____Phone # _____

Most recent physical examination _____Purpose_____

If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.

Have you had any of the following diseases or problems?

	Yes	No
Active Tuberculosis	☐	☐
Persistent cough greater than a 3 week duration	☐	☐
Cough that produces blood	☐	☐

What is your estimate of your general health? Poor _____Fair _____ Good _____

Has there been any change in your general health within the past year? _____

What medicines are you taking? Prescribed: _____

Over the counter: _____

Vitamins, natural or herbal preparation and/or diet supplements: _____

Answer yes or no to the following questions:	Yes	No
Have you had an allergic reaction to?		
aspirin, ibuprofen,	☐	☐
penicillin or other antibiotic	☐	☐
codeine or other narcotic	☐	☐
local anesthetic	☐	☐
fluoride	☐	☐
metals (gold, stainless steel)	☐	☐
latex	☐	☐
any other medications _____		
Have you ever had the following?		
Abnormal bleeding	☐	☐
AIDS or HIV infection	☐	☐
Anemia	☐	☐
Arthritis (or Rheumatoid arthritis)	☐	☐
Artificial prosthesis (heart valve or joints)	☐	☐
If yes, date _____		
Asthma	☐	☐
Blood transfusion, if yes what date? _____	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐
Cardiovascular disease, if yes specify below	☐	☐
_____ Angina		
_____ Arteriosclerosis		
_____ Congenital heart defect		
_____ Congestive heart failure		
_____ Damaged heart valves		
_____ Coronary artery disease		
_____ Heart Attack		
_____ Heart murmur		
_____ High blood pressure		
_____ Low blood pressure		
_____ Mitral valve prolapse		
_____ Pacemaker		
_____ Rheumatic heart disease or fever		
Chest Pain on exertion	☐	☐
Chronic pain	☐	☐
Disease, drug, or radiation-induced immunosuppression	☐	☐
Diabetes, ____ Type I insulin dependent, _____ Type II	☐	☐
Eating disorder or malnutrition	☐	☐
Emphysema, bronchitis or COPD	☐	☐
Epilepsy, convulsions (seizures)	☐	☐
Fainting spells or seizures	☐	☐

	Yes	No
Gastrointestinal disease	☐	☐
GE Reflux/persistent heartburn	☐	☐
Glaucoma	☐	☐
Head or neck injuries	☐	☐
Hemophilia	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Hives, skin rash, hay fever	☐	☐
History of tobacco use (eg cigs, cigars, smokeless)	☐	☐
Recurrent infections	☐	☐
Kidney problems	☐	☐
Mental health disorders, if yes specify _____	☐	☐
Migraines or severe headaches	☐	☐
Night sweats	☐	☐
Neurological disorders, if yes specify _____	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands of neck	☐	☐
Sinus trouble	☐	☐
Sleep disorder	☐	☐
Sores or ulcers in the mouth	☐	☐
Stroke	☐	☐
Thyroid problems	☐	☐
Tumor, abnormal growth	☐	☐
Ulcers	☐	☐
Excessive urination	☐	☐
Viral infections and cold sores	☐	☐
Other condition that we should be aware of _____		

WOMEN ONLY

Are you or could you be pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐

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 Remakrs: _____

Doctor's Signature_____