# DENTAL HISTORY

How did you hear about our practice_____

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? 3 mo._____ 4 mo._____ 6 mo._____ 1 year or longer_____

**WHAT IS YOUR IMMEDIATE DENTAL CONCERN?**_____

| **PLEASE ANSWER YES OR NO TO THE FOLLOWING:** | YES | NO |
|---|---|---|
| 1. unhappy with the appearance of your teeth | ❑ | ❑ |
| 2. unfavorable dental experiences | ❑ | ❑ |
| 3. dental fears | ❑ | ❑ |
| 4. problems with effectiveness or bad reactions to dental anesthetic | ❑ | ❑ |
| 5. orthodontic treatment (braces) when | ❑ | ❑ |
| 6. periodontal (gum) treatment when | ❑ | ❑ |
| 7. bleeding gums | ❑ | ❑ |
| 8. avoid brushing any part of your mouth | ❑ | ❑ |
| 9. part of your mouth is sensitive to temperature | ❑ | ❑ |
| 10. sore teeth | ❑ | ❑ |
| 11. a burning sensation in your mouth | ❑ | ❑ |
| 12. difficulty swallowing | ❑ | ❑ |
| 13. an unpleasant taste or odor in your mouth | ❑ | ❑ |
| 14. dry mouth, throat, and or eyes | ❑ | ❑ |
| 15. jaw problems (temporomandibular joint) | ❑ | ❑ |
| 16. difficulty opening your mouth widely | ❑ | ❑ |
| 17. stiff neck muscles | ❑ | ❑ |
| 18. awaken with an awareness of your teeth or jaws | ❑ | ❑ |
| 19. tension headaches | ❑ | ❑ |
| 20. clench or grind your teeth | ❑ | ❑ |
| 21. jaw clicking or popping | ❑ | ❑ |
| 22. lost any teeth | ❑ | ❑ |
| 23. do you sweat or tremble a lot during examination | ❑ | ❑ |
| 24. do strange people or places make you afraid | ❑ | ❑ |

**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 Remarks:_____

_____

_____

_____Doctor's Signature_____

OVER

# MEDICAL HISTORY

Patient Name_____Nickname_____Age_____

Name of Physician_____

Most recent physical examination_____Purpose_____

What is your estimate of your general health? Poor____ Fair____ Good____

| **HAVE YOU EVER HAD THE FOLLOWING:** | YES | NO |
|---|---|---|
| 1. hospitalization for illness or injury..... | ❑ | ❑ |
| 2. allergic reaction to | | |
| ❑ aspirin, ibuprofen, acetomenophen | | |
| ❑ penicillin | | |
| ❑ erythromycin | | |
| ❑ tetracycline | | |
| ❑ codeine | | |
| ❑ local anesthetic | | |
| ❑ fluoride | | |
| ❑ metals (gold, stainless steel) | | |
| ❑ latex | | |
| ❑ any other medications_____ | | |
| 3. heart problems..... | ❑ | ❑ |
| 4. heart murmur..... | ❑ | ❑ |
| 5. rheumatic fever..... | ❑ | ❑ |
| 6. scarlet fever..... | ❑ | ❑ |
| 7. high blood pressure..... | ❑ | ❑ |
| 8. low blood pressure..... | ❑ | ❑ |
| 9. a stroke..... | ❑ | ❑ |
| 10. artificial prosthesis (i.e. heart valve or joints) | ❑ | ❑ |
| 11. anemia or other blood disorder..... | ❑ | ❑ |
| 12. prolonged bleeding due to a slight cut..... | ❑ | ❑ |
| 13. emphysema..... | ❑ | ❑ |
| 14. tuberculosis..... | ❑ | ❑ |
| 15. asthma..... | ❑ | ❑ |
| 16. sinus problems..... | ❑ | ❑ |
| 17. kidney disease..... | ❑ | ❑ |
| 18. liver disease..... | ❑ | ❑ |
| 19. jaundice..... | ❑ | ❑ |
| 20. thyroid or parathyroid disease..... | ❑ | ❑ |
| 21. hormone deficiency..... | ❑ | ❑ |
| 22. high cholesterol..... | ❑ | ❑ |
| 23. diabetes..... | ❑ | ❑ |
| 24. stomach or duodenal ulcer..... | ❑ | ❑ |
| 25. digestive disorders..... | ❑ | ❑ |
| 26. arthritis..... | ❑ | ❑ |
| 27. glaucoma..... | ❑ | ❑ |
| 28. contact lenses..... | ❑ | ❑ |
| 29. head or neck injuries..... | ❑ | ❑ |
| 30. epilepsy, convulsions (seizures)..... | ❑ | ❑ |
| 31. viral infections and cold sores..... | ❑ | ❑ |
| 32. any lumps or swelling in the mouth..... | ❑ | ❑ |
| 33. hives, skin rash, hay fever..... | ❑ | ❑ |
| 34. venereal disease..... | ❑ | ❑ |
| 35. hepatitis (type_____)..... | ❑ | ❑ |
| 36. HIV / AIDS..... | ❑ | ❑ |
| 37. tumor, abnormal growth..... | ❑ | ❑ |
| 38. radiation therapy..... | ❑ | ❑ |
| 39. chemotherapy..... | ❑ | ❑ |
| 40. emotional problems..... | ❑ | ❑ |
| 41. psychiatric treatment..... | ❑ | ❑ |
| 42. antidepressant medication..... | ❑ | ❑ |
| 43. alcohol / drug dependency..... | ❑ | ❑ |
| **ARE YOU:** | | |
| 44. presently being treated for any illness | ❑ | ❑ |
| 45. aware of a change in your general health | ❑ | ❑ |
| 46. often exhausted or fatigued..... | ❑ | ❑ |
| 47. subject to frequent headaches..... | ❑ | ❑ |
| 48. a heavy smoker (1 pack or more a day) | ❑ | ❑ |
| 49. considered a touchy person..... | ❑ | ❑ |
| 50. often unhappy or depressed..... | ❑ | ❑ |
| 51. easily upset or irritated..... | ❑ | ❑ |
| 52. FEMALE - taking birth control pills..... | ❑ | ❑ |
| 53. FEMALE - pregnant..... | ❑ | ❑ |
| 54. MALE - prostate disorders..... | ❑ | ❑ |

Please describe any current medical treatment, impending surgery, or other treatment that may possible affect your dental treatment_____

_____

List any medications, herbal supplements, and or vitamins taken within the last two years_____

_____

_____

**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 Remarks:_____

_____

_____Doctor's Signature_____

OVER