Dental History

Patient Name_____Age_____Date_____

Reason for seeking care today:___Exam___ Cleaning____Specific Problem_____

_____

Please check all that apply: (Please describe)
❑Toothache
❑ Bite or teeth have shifted
❑ Cracked, chapped lip
❑ Unable to open mouth wide
❑ Broken filling or tooth
❑ Often bite cheeks 1:1 Bad taste in mouth
❑ Jaw gets tired easily. Sensitivity to:
❑ Frequent dry mouth
❑ Sinus problems
❑ Hold things between teeth
❑ Cold
❑ Concerned about breath
❑ Mouth breathe — Difficulty (Pipe, pencil, nails, pins)
❑ Hot
❑ Unhappy with previous breathing through nose
❑ Bite fingernails
❑ Sweets dental work
❑ Dry or strained eyes
❑ Unusual habits with teeth
❑ Chewing
❑ Gums bleed
❑ Shoulder, neck or headaches
❑ Wore braces
❑Food catches
❑ Gums tender
❑ Clench or grind teeth
❑ Previous gum treatment
❑ Loose teeth
❑ Growths, sores
❑ Jaw joint pain
❑ Previous bite treatment
❑ Floss breaks easily or hurts
❑ Cold sores, fever blisters
❑ Clicking or popping of joint.

Would you like whiter teeth?_____

Is there anything that bothers you (even just a little bit) about the appearance of your teeth or smile?

_____
Please rate 1-10 how anxious you are about dental treatment (1= totally relaxed)

_____
Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?)

_____
Why did you leave your previous dentist?

_____
Did your parents have difficulties with their teeth or dental treatments?

Medical History

Physicians Name:_____

City:_____ Phone: _____ Have you been hospitalized for any reason? Please describe:

_____

Are you taking any medications or drugs (including nutritional supplements?) Please list: (Continue on back of form if needed)

_____

Are you taking or have ever taken Bisphosphonates? If yes, name of drug and how long taken.

_____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, jewelry, metal, tetracycline, food allergies, other?

_____

Do you smoke? How much/day?_____

Pregnant? Due date_____

Are you nursing? _____Are you seeing a physician now or planning to see

one for any reason? _____

Please explain: (Continue on back of form if needed)
Please check all that apply:

❑Depression
❑ Psychotic problems
❑ Sinus Problems
❑ Previous injury to head or neck
❑T8
❑ STD
❑ Shingles
❑Heart problem
❑ Diabetes
❑ Digestive problem, ulcer
❑ Shortness of breath
❑ HeartAttack
❑ HIV or AIDS
❑ Thyroid disease
❑ Snoring, sleep apnea
❑ Angina, chest pain
❑ Kidney problem
❑ Glaucoma
❑ No energy
❑ Heart murmur
❑ Liver problem, jaundice
❑ Bleed or bruise easily
❑ Fainting or dizzy

❑ Scarlet, Rheumatic fever
❑ Cirrhosis, Hepatitis
❑ Stroke
❑ Unexplained weight loss
❑ Mitral valve prolapse
❑ Cancer, Radiation, Chemotherapy
❑ Epilepsy or Seizures
❑ Chewing tobacco
❑ Irregular heartbeat
❑ Respiratory problem
❑ Parkinson's
❑ Drug or alcohol addiction
❑ High or low blood pressure
❑ Bloody, persistent cough
❑ Alzheimer's
❑ 2 or more social drinks/day
❑ Pacemaker
❑ Asthma, Emphysema
❑ Back problem
❑ Anxiety or nervous disorder
❑ Artificial joint, bones, valves
❑ Anemia
❑ Hives, rash
❑ Insomnia
❑ Neurological disorders
❑ Sickle cell disease
❑ Dry eyes
❑ Contact lenses
❑ Osteoporosis (list meds)
❑ Colitis
❑ Herpes/Fever BIsiters

Any other illnesses not checked above?

_____

Please indicate if you would prefer to speak privately with the dentist about a medical issue:

❑Yes ❑ No

Please rate the following indicators of your daily stress level: 1-10 : (1 = low, 10 = high)

Overworked, too busy, pressured_____ Feel frustrated_____

Get upset or "snap" easily _____Depression, anxiety_____

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian)_____ Date_____

Dentist' Signature Dare_____Date_____