DENTAL HISTORY

PATIENT ________________________ **D.O.B.** _________________

Comments

1.Purpose of initial visit:______________________________________
____
2.Are you aware of any problems?_________________________________
3.How long since your last dental visit?____________________________
4.What was done at that time?____________________________________
5.Previous Dentist's Name:_______________________________________
Address:____
6.When was the last time your teeth were cleaned?___________________

CIRCLE THE APPROPRIATE ANSWER

7.Have you made regular visits?..Yes No Unsure
How often:____
8.Were dental x-rays taken?..Yes No Unsure
9. Have you lost any teeth or have any teeth been removed?........Yes No Unsure
Why?____
10.Have they been replaced?..Yes No Unsure
11.How were they replaced? Fixed bridge Partial Denture Implant Other
How old are replacements?:____
12.Are you unhappy with the replacement?................................Yes No Unsure
13.Would you like to know about permanent replacements?......Yes No Unsure
14.Have you had problems/complications with previous
dental treatment?.. Yes No
15.Do you clench or grind your teeth?.......................................Yes No Unsure
16.Have you experienced any pain or soreness in the muscles of your
face, around your ears, temples or jaw?..................................Yes No Unsure
17.Do you have frequent headaches?…………………………....Yes No Unsure
18.Does food get caught in your teeth?.......................................Yes No Unsure
19.Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweets? ☐ Pressure?
20.Do your gums bleed or hurt?..Yes No Unsure
When?____
21.When do you brush your teeth?_________________________________
22.Do you use dental floss?...........Yes No How often?__________________
23.Are any of your teeth loose, tipped, shifted or chipped?...…....Yes No Unsure
24.Are you unhappy with the appearance of your teeth?............Yes No Unsure
25. Would you like to have whiter teeth?....................................Yes No Unsure
26.Do you feel your breath is offensive at times?.......................Yes No Unsure
27.Have you ever had gum treatment or surgery?.......................Yes No Unsure
28.Have you had any orthodontic work?....................................Yes No
29.Have you ever had any unpleasant dental experiences or is there anything about
dentistry that you strongly dislike?..Yes No
30. Please rate your dental fear (10 being worst) 1 2 3 4 5 6 7 8 9 10
31. Are you interested in sedation for long appointments?...........Yes No Unsure
32. Do you have any questions or concerns about your teeth in general?...Yes No

____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE & ACCURATE

Patient's / Guardian's Signature:____________________________________Date:________________

Dentist's Signature:____Date:________________

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MEDICAL HISTORY

CIRCLE THE APPROPRIATE ANSWER.

PATIENT:

D.O.B.

1.Physician's Name:____
Address:____
Phone:____
2.Are you under a physician's care?..Yes No
Since when:____________________Why?__________________
3.Have you been hospitalized within the last 5 yrs?____________________
4.Please list **all** medications/supplements you are currently taking & why at right.
5.Are you pregnant or suspect you may be?...Yes No
6.Do you use birth control medication?..Yes No
7.Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment for bone tumor, excessive calcium in blood, or osteoporosis?...............................Yes No
8.Have you ever bled excessively after being cut or injured?..................................Yes No

Allergies

- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other Antibiotics
- ☐ Barbiturates
- ☐ Sedatives
- ☐ Iodine
- ☐ Aspirin
- ☐ Any Metals
- ☐ Latex Rubber
- ☐ Codeine
- ☐ None
- ☐ Other:

9. Do you have or have you had any of the following:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer/Leukemia
- ☐ Chest Pains
- ☐ Diabetes
- ☐ Easily Winded
- ☐ Emphysema/COPD
- ☐ Epilepsy/Seizure Disorder
- ☐ Frequently Tired
- ☐ Hay Fever
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapes
- ☐ Premedicate
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid Problems
- ☐ Dizziness
- ☐ Sinus Problems
- ☐ Other:______

10.Do you or have you had T.B.?.. ..Yes No
11.Do you smoke, chew use snuff or any other form of tobacco?............................ .Yes No
12.Do you regularly consume more than one or two alcoholic beverages a day?..... .Yes No
13.Do you habitually use controlled substances?..Yes No
14.Have you had psychiatric treatment?...Yes No
15.Have you taken Fen-phen, Redux, or other weight loss products?........................Yes No
16.Do you have any disease condition, or problem not listed? If so, explain:____________
17.Is there anything else we should know about your health ?..................................Yes No
18.Would you like to speak to the Doctor privately about any problem?..................Yes No

Medications/Supplements

____

Office Use

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE & ACCURATE

Patient's / Guardian's Signature:____________________________________Date:________________

Dentist's Signature:____Date:________________

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