



DENTAL HISTORY

PREVIOUS DENTIST: _____ LAST DENTAL EXAM: _____

HOW OFTEN DO YOU HAVE YOUR TEETH CLEANED? **3 MO** **4 MO** **6 MO** **1 YEAR +**

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

COMMENTS:

- Y N ARE YOU CURRENTLY IN PAIN? _____
- Y N ARE YOU HAPPY WITH THE WAY YOUR SMILE LOOKS? _____
- Y N HAVE YOU HAD ANY ORTHODONTIC TREATMENT? (BRACES) _____
- Y N HAVE YOU HAD ANY PERIODONTAL TREATMENT? (GUMS) _____
- Y N DO YOUR GUMS EVER BLEED? _____
- Y N ARE YOUR TEETH SORE? _____
- Y N DO YOU HAVE DIFFICULTY SWALLOWING? _____
- Y N DO YOU HAVE ANY JAW PAIN? _____
- Y N DO YOU CLENCH OR GRIND YOUR TEETH? _____
- Y N DOES YOUR JAW CLICK OR POP? _____
- Y N HAVE YOU LOST ANY [PERMANENT] TEETH? _____
- Y N DO YOU STILL HAVE YOUR WISDOM TEETH? _____
- Y N DO YOU HAVE FREQUENT HEADACHES? _____
- Y N DO YOU BRUSH YOUR TEETH DAILY? _____
- Y N DO YOU FLOSS DAILY? _____
- Y N DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL WORK? _____
- Y N HAVE YOU EXPERIENCED PROBLEMS WITH ANESTHETICS? _____
- Y N DO YOU HAVE SLEEP APNEA / USE A C.P.A.P. MACHINE / SNORE EXCESSIVELY? _____

WHAT ONE THING WOULD YOU CHANGE ABOUT YOUR SMILE/TEETH IF YOU COULD?



MEDICAL HISTORY

NAME OF PHYSICIAN: _____ PHONE #: () _____

DATE OF MEDICAL VISIT: _____ REASON: _____

YOUR CURRENT PHYSICAL HEALTH IS: ___ GOOD ___ FAIR ___ POOR

DO YOU SMOKE OR USE TOBACCO IN ANY OTHER FORM: **Y N**

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- | | | |
|----------------|-----------------------|-----------------|
| Y N ASPIRIN | Y N DENTAL ANESTHETIC | Y N IBUPROFEN |
| Y N PENICILLIN | Y N SULFA DRUGS | Y N LATEX |
| Y N CODEINE | Y N ERYTHROMYCIN | Y N ACRYLLIC |
| Y N SEDATIVES | Y N TETRACYCLINE | Y N GLUTEN |
| | | Y N OTHER _____ |

FOR WOMEN: ARE YOU ... PREGNANT? **Y N** ...TAKING ORAL CONTRACEPTIVES? **Y N** ...NURSING? **Y N**

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING: _____

HAVE YOU EXPERIENCED/BEEN TREATED FOR ANY OF THE FOLLOWING?

- | | | |
|-----------------------------------|--------------------------------|--------------------------------------|
| Y N ABNORMAL BLEEDING | Y N HEART ATTACK / SURGERY | Y N PACEMAKER |
| Y N ANAPHYLAXIS / SEVERE ALLERGY | Y N HEART MURMUR / ARRYTHMIAS | Y N RHEUMATIC / SCARLET FEVER |
| Y N ANEMIA | Y N HEMOPHILIA/BLEEDING EASILY | Y N PERSISTENT COUGH |
| Y N ANGINA / CHEST PAIN | Y N HEPATITIS A / B / C (HCV) | Y N SEIZURES / EPILEPSY |
| Y N ARTIFICIAL VALVES / JOINTS | Y N HERPES/FEVER BLISTERS | Y N SINUS PROBLEM / SEASONAL ALLERGY |
| Y N ASTHMA / DIFFICULTY BREATHING | Y N HIGH BLOOD PRESSURE | Y N STEROID THERAPY |
| Y N BLOOD DISEASE / TRANSFUSION | Y N HIV+ / AIDS | Y N STROKE |
| Y N CANCER/CHEMO / RADIATION | Y N KIDNEY DISEASE | Y N THYROID DISEASE |
| Y N CONGENITAL HEART DISORDER | Y N LIVER DISEASE | Y N TUBERCULOSIS (TB) |
| Y N DIABETES/HYPOGLYCEMIA | Y N MITRAL VALVE PROLAPSE | Y N ULCERS / INTESTINAL DISORDER |
| Y N FAINTING SPELLS / SYNCOPE | Y N OSTEOPOROSIS | Y N OTHER _____ |

WHO MAY WE THANK FOR REFERRING YOU? _____