HEALTH HISTORY

Patient Name ______________________________

Describe your general health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you under the care of a physician or health care provider? ☐ Yes ☐ No

Have you been advised to take antibiotics before dental care? ☐ Yes ☐ No

MEDICAL ALERTS

____

____

____

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
Allergic or adverse reaction to:		
aspirin, ibuprofen, acetaminophen ________	☐	☐
penicillin or other antibiotics ________	☐	☐
codeine or other narcotics ________	☐	☐
local anesthetic ________	☐	☐
fluoride ________	☐	☐
metals ________	☐	☐
latex or other dental materials ________	☐	☐
any other medications ________	☐	☐
Heart problems		
heart murmur ________	☐	☐
rheumatic fever ________	☐	☐
heart surgery ________	☐	☐
heart valve ________	☐	☐
High blood pressure ________	☐	☐
Low blood pressure ________	☐	☐
Alcohol or drug abuse ________	☐	☐
Anemia or other blood disorder ________	☐	☐
Arthritis ________	☐	☐
Asthma ________	☐	☐
Breathing/Sleep problems ________	☐	☐
Cancer/Tumor ________	☐	☐
chemotherapy ________	☐	☐
radiation therapy ________	☐	☐
Anxiety / Panic Attacks ________	☐	☐
Diabetes (type ______) ________	☐	☐
Digestive disorders (i.e. gastric reflux) ________	☐	☐

	YES	NO
Eating Disorder ________	☐	☐
Emphysema ________	☐	☐
Epilepsy, convulsions (seizures) ________	☐	☐
Frequent headaches ________	☐	☐
Glaucoma ________	☐	☐
Head or neck injuries ________	☐	☐
Hearing aid ________	☐	☐
Hepatitis (type ______) ________	☐	☐
High cholesterol ________	☐	☐
Hives, skin rash, hay fever ________	☐	☐
HIV/AIDS ________	☐	☐
Joint replacement ________	☐	☐
Kidney disease ________	☐	☐
Liver disease ________	☐	☐
Lumps or swelling in the mouth ________	☐	☐
Mental health problems ________	☐	☐
Neurological problems ________	☐	☐
Osteoporosis/osteopenia ________	☐	☐
Smoke or tobacco use ________	☐	☐
Stroke ________	☐	☐
Thyroid (type ______) ________	☐	☐
Viral infections (i.e. cold sores) ________	☐	☐
Ulcers ________	☐	☐
Female		
Taking birth control pills ________	☐	☐
Pregnant ________	☐	☐

List any medications, supplements, and or vitamins you are currently taking:

Drug	Reason	Drug	Reason

Comments: ______________________________

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Patient Signature ______________________________ Dr. Initials ________ Date ____________

DENTAL HISTORY

Immediate concern ____________________

Date and type of last dental visit ____________________

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PERSONAL HISTORY

	YES	NO
How anxious are you about dental treatment on a scale of 0 (not at all) to 10 (very) _______		
Have you ever had an unfavorable dental experience?	☐	☐
Have you ever had complications from past dental treatment?	☐	☐
Have you ever had trouble getting numb or reactions to local anesthetic?	☐	☐
Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
Have you had any teeth removed?	☐	☐

SMILE CHARACTERISTICS

	YES	NO
Is there anything about the appearance of your teeth that you would like to change?	☐	☐
Are you self conscious about your teeth or smile?	☐	☐
Have you been disappointed with the appearance of previous dental work?	☐	☐
Have you ever whitened (bleached) your teeth?	☐	☐

BITE AND JAW JOINT

	YES	NO
Do you have any problems chewing gum?	☐	☐
Do you/would you have any problems chewing bagels or other hard food?	☐	☐
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
Are your teeth crowding or developing spaces?	☐	☐
Do you have more than one bite or do you clench or squeeze to make your teeth fit together?	☐	☐
Do you clinch or grind your teeth or wake up with an awareness of your teeth?	☐	☐
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
Do you have tension headaches or sore teeth?	☐	☐
Do you wear or have you ever worn a bite appliance?	☐	☐

TOOTH STRUCTURE

	YES	NO
Have you had any cavities in the past 3 years?	☐	☐
Do you have a dry mouth?	☐	☐
Are any teeth sensitive to hot, cold, biting or sweets?	☐	☐
Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	☐	☐
Do you feel or notice any holes in your teeth?	☐	☐
Do you avoid brushing any part of your mouth?	☐	☐

GUM AND BONE

	YES	NO
Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
Is there anyone with a history of periodontal disease in your family?	☐	☐
Have you ever experienced gum recession?	☐	☐
Do your gums bleed when brushing, flossing or eating?	☐	☐
Are your teeth becoming loose?	☐	☐
Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐

Comments: ____________________

____________________ Date __________

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Patient Signature ______________________________ Dr. Initials ______ Date ______________