



DENTAL HISTORY

Name _____ Date ____ / ____ / ____

What is your main dental concern _____

Are you happy with the way your teeth look _____

Would you like your teeth to be whiter _____

What changes would you make about your mouth _____

Dental experiences with dentist(s) in past (describe) _____

Check all previous services received at other dental facilities

- Dental exam/x-rays
- Tooth extractions
- Periodontal treatment (gum treatment)
- Partial denture (removable)
- Crown and bridge work (fixed)
- Endodontic treatment (root canal treatment)
- Complete dentures
- Orthodontic treatment (braces)

Self analysis of oral health (check any problems that you have)

- Bad teeth
- Crooked teeth
- Dry Mouth
- Do you experience pain or clicking in your jaw, ear or facial muscles?
- Are you aware of grinding or clenching your teeth?
- Bleeding gums
- Loose or drifting teeth
- Food catching between teeth
- Teeth painful to hot, cold, sweets
- Bad taste in mouth
- Bite feels off
- Receding gums

MEDICAL HISTORY

- Has there been a recent change in health?
If yes, Condition _____
- Are you under the care of a physician?
If yes, Condition _____
- Have you been hospitalized or had a serious illness within the last year?
If yes, why? _____
- Do you smoke cigarettes? Packs per day _____ years _____
- Do you chew tobacco? times per day _____ years _____

CARDIOVASCULAR	<input type="checkbox"/> Have you ever been told you have heart trouble? <input type="checkbox"/> Have you ever been told you have <input type="checkbox"/> high or <input type="checkbox"/> low blood pressure? <input type="checkbox"/> Have you ever had rheumatic fever? <input type="checkbox"/> Do you have a prolapsed mitral valve? <input type="checkbox"/> Have you ever been told you have a heart murmur? <input type="checkbox"/> Have you ever been told to take antibiotics before a dental procedure? <input type="checkbox"/> Have you ever had a heart attack? Date _____ <input type="checkbox"/> Have you had a stroke? Date _____ <input type="checkbox"/> Do you suffer from angina (chest and left arm pain)?	HEMATOLOGY	<input type="checkbox"/> Have you had anemia? <input type="checkbox"/> Do you have leukemia? <input type="checkbox"/> Do you take any blood thinners? Type _____
RESPIRATORY	<input type="checkbox"/> Do you have hay fever or frequent sinusitis? <input type="checkbox"/> Do you have, or have you been exposed to tuberculosis? <input type="checkbox"/> Do you have bronchitis or emphysema? <input type="checkbox"/> Do you have asthma?	IMMUNOLOGY	<input type="checkbox"/> Are you sensitive or allergic to any medications such as Penicillin, Codeine, Aspirin, Tylenol or Valium? <input type="checkbox"/> Are you allergic to latex rubber? <input type="checkbox"/> Do you have a defective immune system? <input type="checkbox"/> Do you take medications that suppress your immune system? <input type="checkbox"/> AIDS or HIV infection
NEUROLOGY	<input type="checkbox"/> Do you have numbness or tingling anywhere? <input type="checkbox"/> Have you ever had a nervous breakdown? <input type="checkbox"/> Are you anxious or depressed frequently? <input type="checkbox"/> Do you have epilepsy, seizures, or other neurological disorders?	M-S	<input type="checkbox"/> Are your joints often painfully swollen or do you have arthritis? <input type="checkbox"/> Do you have osteoporosis?
ENDOCRINE & G-I/G-U	<input type="checkbox"/> Do you have diabetes? <input type="checkbox"/> Do you have thyroid problems or take thyroid tablets? <input type="checkbox"/> Have you had jaundice, liver problems? <input type="checkbox"/> Do you have hepatitis? Type _____ <input type="checkbox"/> Do you have stomach problems or ulcers? <input type="checkbox"/> Do you have frequent episodes of acid reflux or vomiting? <input type="checkbox"/> Do you have kidney problems <input type="checkbox"/> Are you currently having hemodialysis treatment?	SURGERY ANESTHESIA	<input type="checkbox"/> Have you ever been told not to take Lidocaine or any other local anesthesia? <input type="checkbox"/> Have you ever had chemotherapy? <input type="checkbox"/> Have you ever had radiation therapy? <input type="checkbox"/> Are you using any recreational drugs or substances? <input type="checkbox"/> Are you an active or recovering substance abuser?
		IMPLANTS	<input type="checkbox"/> Do you have a prosthetic heart valve? <input type="checkbox"/> Do you have a pacemaker? <input type="checkbox"/> Do you have any prosthetic joints?
		WOMEN	<input type="checkbox"/> Are you taking birth control pills? <input type="checkbox"/> Are you pregnant? Expected delivery Date: _____ <input type="checkbox"/> Are you breast feeding?

I certify that I have read and understand the above, I acknowledge that my questions, if any, about inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other members of his staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN _____

DATE _____

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