

Dental History

Patient Name _____ Age _____ Date _____

Reason for seeking care today: ___ Exam ___ Cleaning ___ Specific Problem _____
(Please describe)

Please check all that apply:

Sensitivity to:			
<input type="checkbox"/>	Cold	<input type="checkbox"/>	Bite or teeth have shifted
<input type="checkbox"/>	Hot	<input type="checkbox"/>	Often bite cheeks
<input type="checkbox"/>	Sweets	<input type="checkbox"/>	Frequent dry mouth
<input type="checkbox"/>	Chewing	<input type="checkbox"/>	Concerned about breath
<input type="checkbox"/>	Food catches	<input type="checkbox"/>	Unhappy with previous dental work
<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>	Gums bleed
<input type="checkbox"/>	Floss breaks easily or hurts	<input type="checkbox"/>	Gums tender
<input type="checkbox"/>	Biting Down on any tooth	<input type="checkbox"/>	Growth, sores
<input type="checkbox"/>	Broken filling or tooth	<input type="checkbox"/>	Cold sores, fever blisters
		<input type="checkbox"/>	Cracked, chapped lips
		<input type="checkbox"/>	Bad taste in mouth
		<input type="checkbox"/>	Sinus problems
		<input type="checkbox"/>	Mouth breather – asleep or awake
		<input type="checkbox"/>	Dry or strained eyes
		<input type="checkbox"/>	Shoulder, neck or headaches
		<input type="checkbox"/>	Clench or grind teeth
		<input type="checkbox"/>	Jaw joint pain
		<input type="checkbox"/>	Clicking or popping of joint.
		<input type="checkbox"/>	Unable to open mouth wide
		<input type="checkbox"/>	Jaw gets tired easily.
		<input type="checkbox"/>	Hold things between teeth (Pipe, pencil, nails, pins)
		<input type="checkbox"/>	Bite fingernails
		<input type="checkbox"/>	Unusual habits with teeth
		<input type="checkbox"/>	Wore braces
		<input type="checkbox"/>	Previous gum treatment
		<input type="checkbox"/>	Previous bite treatment

Would you like whiter teeth? _____

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?) What happened? _____

Why did you leave your previous dentist? _____

Medical History

Physicians Name _____ City _____

Have you been hospitalized for any reason? Please describe:

Are you taking any medications or drugs (including nutritional supplements?) Please list:

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, 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:

Please check all that apply:

<input type="checkbox"/>	Previous injury to head or neck	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Digestive problem, ulcer	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	HIV or AIDS	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	Snoring, sleep apnea
<input type="checkbox"/>	Angina, chest pain	<input type="checkbox"/>	Kidney problem	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Easily winded
<input type="checkbox"/>	Heart murmur,	<input type="checkbox"/>	Liver problem, jaundice	<input type="checkbox"/>	Bleed or bruise easily	<input type="checkbox"/>	No energy
<input type="checkbox"/>	Scarlet, rheumatic fever	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Fainting or dizzy
<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	Radiation, chemo.	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	Unexplained weight loss
<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	Respiratory problem	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	Chewing tobacco
<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Bloody, persistent cough	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	Drug or alcohol addiction
<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	Asthma, Emphysema.	<input type="checkbox"/>	Back problem	<input type="checkbox"/>	2 or more social drinks/day
<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Hives, rash, Herpes	<input type="checkbox"/>	Anxiety or nervous disorder
<input type="checkbox"/>	Contact lenses	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	Insomnia

Any other illnesses not checked above: _____

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 _____ Date _____