DENTAL HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty chewing your food?	☐	☐
Do you chew only on one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores or lumps in your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you have dry mouth?	☐	☐
Do your feel twinges of pain when your teeth come in contact with:		
• Hot foods or liquids?	☐	☐
• Cold foods or liquids?	☐	☐
• Sours?	☐	☐
• Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Are you happy with the shape and color of your teeth?	☐	☐
Have you ever had a biopsy of an oral cyst or lesion?	☐	☐
Is there any history of oral surgeries, including wisdom tooth extractions?	☐	☐
Have you ever had a difficult extraction?	☐	☐
Have you had orthodontic treatment?	☐	☐

	Yes	No
Have you ever had periodontal treatment?	☐	☐
Do you breathe through your mouth?	☐	☐
Have you been diagnosed with sleep apnea?	☐	☐
Does your jaw make noise so that it bothers you or others?	☐	☐
Do your clench or grind your teeth frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so you can't open freely?	☐	☐
Does it hurt when you chew or open wide?	☐	☐
Do your have earaches or pain in front of the ears?	☐	☐
Do you have any jaw pain or headaches upon waking in the morning?	☐	☐
Do you take medications for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a TMJ disorder?	☐	☐
Do your have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Have you ever had a head, neck, or jaw injury?	☐	☐
Do you bite or chew your lips or cheeks frequently?	☐	☐
Have you ever had instructions on the care of your gums?	☐	☐
Have you ever had instructions on the correct method of brushing your teeth?	☐	☐
Are you in pain?	☐	☐
How long? _____		
Have you ever been told you need to take an antibiotic before dental treatments?	☐	☐

How often do you brush? _____
How often do you floss? _____
What type of toothbrush bristles? Soft ☐ Medium ☐ Hard ☐
Former Dentist _____ Reason for leaving_____

MEDICAL HISTORY

Do you have, or have you ever had, any of the following?

	Yes	No
Heart problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Artificial heart valve	☐	☐
Angina	☐	☐
Circulatory problems	☐	☐
Take medication for blood thinning	☐	☐
Ever taken Fen-Phen or Redux?	☐	☐
Have a Pacemaker	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Leukemia	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Crohn's Disease	☐	☐
Bone or Joint Problems	☐	☐

	Yes	No
Rheumatism	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement/pins/implants	☐	☐
Emphysema	☐	☐
Fainting spells, seizures or epilepsy	☐	☐
Stroke	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough	☐	☐
Swollen glands	☐	☐
Antibiotic pre-medication required by physician for dental treatment?	☐	☐
Cancer/Tumor	☐	☐
Cancer survivor	☐	☐
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Osteoporosis	☐	☐
Do you take medication for Osteoporosis?	☐	☐
Diabetes	☐	☐
Family history of diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Insulin dependent	☐	☐
Oral medication	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? _____		
Do you use tobacco?	☐	☐
• Chew? ☐ Smoke? ☐		
• How long? _____		

	Yes	No
• How much? _____		
Former tobacco user?	☐	☐
• How long? _____		
• How long quit? _____		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV positive/AIDS or other Immunosuppressive disorder	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Neurological disease?	☐	☐
History of alcohol or drug abuse	☐	☐
Chemical dependency	☐	☐
Swollen feet or ankles	☐	☐
Tonsillitis	☐	☐
Shingles	☐	☐
Cosmetic surgery	☐	☐
Mental or nervous disorder	☐	☐
Women:		
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant or think you might be?	☐	☐
If so, expected delivery date: ___/___/____		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms?	☐	☐

Please Describe:
_____
_____
_____
_____
_____

Medicines and Drugs

Are you allergic, or have you reacted adversely, to any of the following:

	Yes	No
• Local anesthetics (“Novocaine”)	☐	☐
• Penicillin or other antibiotics	☐	☐
• Sulfa drugs	☐	☐
• Barbiturates, sedatives or sleeping pills	☐	☐
• Aspirin, Acetaminophen, or Ibuprofen	☐	☐
• Codeine, Demerol, or other narcotics	☐	☐
• Latex or rubber dam	☐	☐
• Iodine	☐	☐
• Other_____		

During the past 12 months have you taken any of the following?

	Yes	No
• Antibiotics or sulfa drugs	☐	☐
• Anticoagulants (such as Coumadin, Warfarin)	☐	☐
• High blood pressure medicine	☐	☐
• Tranquilizers	☐	☐
• Aspirin	☐	☐
• Digitalis or drugs for heart trouble	☐	☐
• Nitroglycerin	☐	☐
• Cortisone (steroids)	☐	☐
• Natural Remedies	☐	☐
• Nonprescription drugs	☐	☐
• Supplements	☐	☐
• Other	☐	☐

Have you had any serious illnesses or surgeries? Yes ☐ No ☐

Please describe:

_____

_____

_____

_____

_____

_____

Is there anything else we should know about your health?

_____

_____

_____

_____

_____

_____

Please list all medications and supplements you are currently taking:

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Emergency Contact Information:

In the event of an emergency, whom should we contact?

Name _____ Phone (_____) _____-_____

Relationship _____

Who is your medical doctor? _____ Phone (_____) _____-_____

To the best of my knowledge all of the preceding answers and information are true and correct. If I have any change in my health I will inform the doctor at the next appointment.

Date: ____/____/_____ Signature: _____