DENTAL HISTORY

Referred by ______________________

Previous dentist ______________________ How long ______________________

Most recent dental exam ______________________ Most Recent dental x-ray ______________________

Most recent dental treatment ______________________

How often do you have your teeth cleaned? 3 mo._____ 4 mo._____ 6 mo._____ 1 year or longer_____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? ______________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
1. unhappy with the appearance of your teeth	☐	☐
2. unfavorable dental experiences	☐	☐
3. dental fears	☐	☐
4. problems with effectiveness or bad reactions to dental anesthetic	☐	☐
5. orthodontic treatment (braces) when	☐	☐
6. periodontal (gum) treatment when	☐	☐
7. bleeding gums	☐	☐
8. avoid brushing any part of your mouth	☐	☐
9. part of your mouth is sensitive to temperature	☐	☐
10. sore teeth	☐	☐
11. a burning sensation in your mouth	☐	☐
12. difficulty swallowing	☐	☐
13. an unpleasant taste or odor in your mouth	☐	☐
14. dry mouth, throat, and or eyes	☐	☐
15. jaw problems (temporomandibular joint)	☐	☐
16. difficultly opening your mouth widely	☐	☐
17. stiff neck muscles	☐	☐
18. awaken with an awareness of your teeth or jaws	☐	☐
19. tension headaches	☐	☐
20. clench or grind your teeth	☐	☐
21. jaw clicking or popping	☐	☐
22. lost any teeth	☐	☐
23. do you sweat or tremble a lot during examination	☐	☐
24. do strange people or places make you afraid	☐	☐

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES	NO	(Please check Yes or No)
☐	☐	Has your present denture been relined? When ______________________
☐	☐	Is your present denture a problem? Describe ______________________
☐	☐	Satisfied with the appearance? ______________________
☐	☐	Satisfied with the comfort? ______________________
☐	☐	Satisfied with the chewing ability? ______________________
		When did you receive your first partial or complete denture? ______________________
		How long have you worn your present denture? ______________________

Patient's Signature ______________________ Date ______________________

Doctor's Remarks: ______________________

______________________ Doctor's Signature ______________________

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MEDICAL HISTORY

Patient Name________________________ Nickname____________________ Age __________

Name of Physician____

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? Poor ________ Fair ________ Good ________

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury	❑	❑
2. allergic reaction to		
❑ aspirin, ibuprofen, acetomenophen		
❑ penicillin		
❑ erythromycin		
❑ tetracycline		
❑ codeine		
❑ local anesthetic		
❑ fluoride		
❑ metals (gold, stainless steel)		
❑ latex		
❑ any other medications __________		
3. heart problems	❑	❑
4. heart murmur	❑	❑
5. rheumatic fever	❑	❑
6. scarlet fever	❑	❑
7. high blood pressure	❑	❑
8. low blood pressure	❑	❑
9. a stroke	❑	❑
10. artificial prosthesis (i.e. heart valve or joints)	❑	❑
11. anemia or other blood disorder	❑	❑
12. prolonged bleeding due to a slight cut	❑	❑
13. emphysema	❑	❑
14. tuberculosis	❑	❑
15. asthma	❑	❑
16. sinus problems	❑	❑
17. kidney disease	❑	❑
18. liver disease	❑	❑
19. jaundice	❑	❑
20. thyroid or parathyroid disease	❑	❑
21. hormone deficiency	❑	❑
22. high cholesterol	❑	❑
23. diabetes	❑	❑
24. stomach or duodenal ulcer	❑	❑
25. digestive disorders	❑	❑

	YES	NO
26. arthritis	❑	❑
27. glaucoma	❑	❑
28. contact lenses	❑	❑
29. head or neck injuries	❑	❑
30. epilepsy, convulsions (seizures)	❑	❑
31. viral infections and cold sores	❑	❑
32. any lumps or swelling in the mouth	❑	❑
33. hives, skin rash, hay fever	❑	❑
34. venereal disease	❑	❑
35. hepatitis (type ______)	❑	❑
36. HIV / AIDS	❑	❑
37. tumor, abnormal growth	❑	❑
38. radiation therapy	❑	❑
39. chemotherapy	❑	❑
40. emotional problems	❑	❑
41. psychiatric treatment	❑	❑
42. antidepressant medication	❑	❑
43. alcohol / drug dependency	❑	❑
ARE YOU:		
44. presently being treated for any illness	❑	❑
45. aware of a change in your general health	❑	❑
46. often exhausted or fatigued	❑	❑
47. subject to frequent headaches	❑	❑
48. a heavy smoker (1 pack or more a day)	❑	❑
49. considered a touchy person	❑	❑
50. often unhappy or depressed	❑	❑
51. easily upset or irritated	❑	❑
52. FEMALE - taking birth control pills	❑	❑
53. FEMALE - pregnant	❑	❑
54. MALE - Prostate disorders	❑	❑

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment ____

____

List any medications, herbal supplements, and or vitamins taken within the last two years__________________

____

____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature________________________________ Date______________

Doctor's Remarks: ____

________________________ Doctor's Signature________________________

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