

# DENTAL HISTORY

Print Patient's Name: \_\_\_\_\_

## Please check any of the following problems that apply to you

- Sensitivity (hot, cold, sweet, pressure)
- Tooth pain or discomfort when chewing
- Head, ear, neck pain or shoulder ache
- Jaw popping or pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, chipped or shifting teeth
- Food gets caught in my teeth
- Bad breath or bad taste in your mouth

## Do you have or have had any of the following?

- Dentures  Date \_\_\_\_\_
- Partial Denture  Date \_\_\_\_\_
- Braces  Date \_\_\_\_\_
- Periodontal Disease  Date \_\_\_\_\_
- Gum Treatments  Date \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

City/State: \_\_\_\_\_

--Your last oral cancer screening? \_\_\_\_\_

--Your last complete x-rays? \_\_\_\_\_

What is most important to you about your future smile and dental health? \_\_\_\_\_

If you could whiten your teeth for a cost anyone could afford, would you do it?

Do you smoke or use chewing tobacco

How much? \_\_\_\_\_ For how long? \_\_\_\_\_

If I could change my smile, I would:

--Make them brighter

--Make them straighter

--Close spaces

--Replace black metal fillings with tooth colored

--Repair chipped teeth

--Replace missing teeth

--Replace old crowns that don't match

--Have a smile makeover

On a scale of 1-10, with 10 being the highest:

--How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

--Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

I brush my teeth how often? \_\_\_\_\_

When? \_\_\_\_\_

I floss how often? \_\_\_\_\_

When? \_\_\_\_\_

# MEDICAL HISTORY

## Please check any of the following that apply to you:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> AIDS                   | <input type="checkbox"/> Drug Addiction             | <input type="checkbox"/> HIV Positive           | <input type="checkbox"/> Pneumatic Fever   |
| <input type="checkbox"/> Allergies (Seasonal)   | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Rheumatism        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Excessive bleeding         | <input type="checkbox"/> Jaw Joint Pain         | <input type="checkbox"/> Scarlet Fever     |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Stomach Problems  |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Heart Condition            | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart Lesions (congenital) | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Bruise easily          | <input type="checkbox"/> Heart Surgery              | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Hepatitis A                | <input type="checkbox"/> Phen Fen (1month +)    | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Hepatitis B                | <input type="checkbox"/> Pregnant Currently     | <input type="checkbox"/> Fosamax           |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hepatitis C                | <input type="checkbox"/> Radiation              | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Respiratory Problems   |  |

## Do you have any of the following drug allergies?

- Aspirin  Codeine
- Darvon  Erythromycin
- Percodan  Valium
- Nitrous Oxide  Penicillin
- Local Anesthetic  Latex or Metal
- Other \_\_\_\_\_

Family Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Are you under a physician's care? For What? \_\_\_\_\_

Are you taking any medications? What are they? \_\_\_\_\_

Is there any other medical or dental information we should know about? \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature