Dental History

Patient Name _____ Age _____ Date _____

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

Please check all that apply:

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

Would you like whiter teeth? _____
Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?

_____

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:

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

Any other illnesses not checked above: _____
Please indicate if you would prefer to speak privately with the dentist about a medical issue: □ Yes □ No

Please rate your daily stress level: 1-10 (1=lowest stress)
□ Overworked, busy, pressured □ Worried, frustrated □ Get upset or snap easily □ Insomnia, depression, anxiety

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 _____