

# Dental History

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Reason for seeking care today: \_\_\_ Exam \_\_\_ Cleaning \_\_\_ Specific Problem \_\_\_\_\_  
(Please describe)

## Please check all that apply:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Toothache                    | <input type="checkbox"/> Bite or Teeth have Shifted           | <input type="checkbox"/> Cracked, Chapped Lips                              | <input type="checkbox"/> Unable to Open Mouth Wide                                |
| <input type="checkbox"/> Broken filling or tooth      | <input type="checkbox"/> Often Bite Cheeks                    | <input type="checkbox"/> Bad Taste in Mouth                                 | <input type="checkbox"/> Jaw Gets Tired Easily                                    |
| Sensitivity to:                                       | <input type="checkbox"/> Frequent Dry Mouth                   | <input type="checkbox"/> Sinus Problems                                     | <input type="checkbox"/> Hold Things Between Teeth<br>(Pipe, pencil, nails, pins) |
| <input type="checkbox"/> Cold                         | <input type="checkbox"/> Concerned about Breath               | <input type="checkbox"/> Mouth breathe-Difficulty<br>Breathing through Nose | <input type="checkbox"/> Bite Fingernails   |
| <input type="checkbox"/> Hot                          | <input type="checkbox"/> Unhappy with Previous<br>Dental Work | <input type="checkbox"/> Dry or Strained Eyes                               | <input type="checkbox"/> Unusual Habits with Teeth                                |
| <input type="checkbox"/> Sweets                       | <input type="checkbox"/> Gums Bleed                           | <input type="checkbox"/> Shoulder, Neck or Headaches                        | <input type="checkbox"/> Wore Braces  |
| <input type="checkbox"/> Chewing                      | <input type="checkbox"/> Gums Tender                          | <input type="checkbox"/> Clench or Grind Teeth                              | <input type="checkbox"/> Previous Gum Treatment                                   |
| <input type="checkbox"/> Food Catches                 | <input type="checkbox"/> Growths, Sores                       | <input type="checkbox"/> Jaw Joint Pain                                     | <input type="checkbox"/> Previous Bite Treatment                                  |
| <input type="checkbox"/> Loose Teeth                  | <input type="checkbox"/> Cold Sores, Fever Blisters           | <input type="checkbox"/> Clicking or Popping of Joint                       |   |
| <input type="checkbox"/> Floss Breaks easily or hurts |   |   |   |

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?) \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

Did your parents have difficulties with their teeth or dental treatments? \_\_\_\_\_

# Medical History

Physicians Name \_\_\_\_\_

City \_\_\_\_\_ Phone \_\_\_\_\_

Have you been hospitalized for any reason? Please describe:  
\_\_\_\_\_  
\_\_\_\_\_

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

Please list: (continue on back of form if needed) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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"/> Snoring, Sleep Apnea        |
| <input type="checkbox"/> Heart Problem                   | <input type="checkbox"/> HIV or AIDS              | <input type="checkbox"/> Thyroid Disease          | <input type="checkbox"/> Easily Winded               |
| <input type="checkbox"/> Heart Attack                    | <input type="checkbox"/> Kidney Problem           | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> No Energy                   |
| <input type="checkbox"/> Angina, Chest Pain              | <input type="checkbox"/> Liver Problem, Jaundice  | <input type="checkbox"/> Bleed or Bruise Easily   | <input type="checkbox"/> Fainting or Dizzy           |
| <input type="checkbox"/> Heart Murmur                    | <input type="checkbox"/> Cirrhosis, Hepatitis     | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Unexplained Weight Loss     |
| <input type="checkbox"/> Scarlet, Rheumatic Fever        | <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Epilepsy or Seizures     | <input type="checkbox"/> Chewing Tobacco             |
| <input type="checkbox"/> Mitral Valve Prolapse           | <input type="checkbox"/> Radiation, Chemotherapy  | <input type="checkbox"/> Parkinson's              | <input type="checkbox"/> Drug or Alcohol Addiction   |
| <input type="checkbox"/> Irregular Heartbeat             | <input type="checkbox"/> Respiratory Problem      | <input type="checkbox"/> Alzheimer's              | <input type="checkbox"/> 2 or more Social Drinks/Day |
| <input type="checkbox"/> High or Low Blood Pressure      | <input type="checkbox"/> Bloody, Persistent Cough | <input type="checkbox"/> Back Problems            | <input type="checkbox"/> Anxiety or Nervous Disorder |
| <input type="checkbox"/> Pacemaker                       | <input type="checkbox"/> Asthma, Emphysema        | <input type="checkbox"/> Hives, Rash, Herpes      | <input type="checkbox"/> Insomnia                    |
| <input type="checkbox"/> Artificial Joint                | <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Dry Eyes                 | <input type="checkbox"/> Contact Lenses              |
|  | <input type="checkbox"/> Sickle Cell              | <input type="checkbox"/> Shortness of Breath      |  |

Any other illness not checked above \_\_\_\_\_

Please indicate if you would prefer to speak privately with the dentist about a medical issue:  YES  NO

Please rate the following indicators of your daily stress level: 1-10 (1=low, 10=high)

\_\_\_ Overworked, too busy, pressured \_\_\_ Feel Frustrated \_\_\_ Get upset, or "snap" easily \_\_\_ 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's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Medical History Updates

Date: \_\_\_\_\_

Please indicate any changes in your health since we saw you last, i.e. new medications or doses. \_\_\_\_\_

Are you seeing (or planning to see) a doctor for any reason?

\_\_\_\_\_  
\_\_\_\_\_

Patient (Guardian) Signature: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate any changes in your health since we saw you last, i.e. new medications or doses. \_\_\_\_\_

Are you seeing (or planning to see) a doctor for any reason?

\_\_\_\_\_  
\_\_\_\_\_

Patient (Guardian) Signature: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate any changes in your health since we saw you last, i.e. new medications or doses. \_\_\_\_\_

Are you seeing (or planning to see) a doctor for any reason?

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\_\_\_\_\_

Patient (Guardian) Signature: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate any changes in your health since we saw you last, i.e. new medications or doses. \_\_\_\_\_

Are you seeing (or planning to see) a doctor for any reason?

\_\_\_\_\_  
\_\_\_\_\_

Patient (Guardian) Signature: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate any changes in your health since we saw you last, i.e. new medications or doses. \_\_\_\_\_

Are you seeing (or planning to see) a doctor for any reason?

\_\_\_\_\_  
\_\_\_\_\_

Patient (Guardian) Signature: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate any changes in your health since we saw you last, i.e. new medications or doses. \_\_\_\_\_

Are you seeing (or planning to see) a doctor for any reason?

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Patient (Guardian) Signature: \_\_\_\_\_

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Date: \_\_\_\_\_

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Are you seeing (or planning to see) a doctor for any reason?

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\_\_\_\_\_

Patient (Guardian) Signature: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate any changes in your health since we saw you last, i.e. new medications or doses. \_\_\_\_\_

Are you seeing (or planning to see) a doctor for any reason?

\_\_\_\_\_  
\_\_\_\_\_

Patient (Guardian) Signature: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate any changes in your health since we saw you last, i.e. new medications or doses. \_\_\_\_\_

Are you seeing (or planning to see) a doctor for any reason?

\_\_\_\_\_  
\_\_\_\_\_

Patient (Guardian) Signature: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_