



Patient Full Name: _____ Birth Date: _____

DENTAL HISTORY

Please check the appropriate boxes if you currently have, or have experienced:

- | | |
|--|---|
| <input type="checkbox"/> Tooth sensitivity hot, cold, or sweets | <input type="checkbox"/> Burning tongue |
| <input type="checkbox"/> Tooth pain when chewing or biting | <input type="checkbox"/> Previous orthodontic (braces) treatment |
| <input type="checkbox"/> Cracked or Chipped teeth | <input type="checkbox"/> Wear a removable dental appliance |
| <input type="checkbox"/> Bleeding gums, How long? _____ | <input type="checkbox"/> Mouth breathing or Dry mouth |
| <input type="checkbox"/> Pain or soreness in gums | <input type="checkbox"/> Do you snore? |
| <input type="checkbox"/> Food impaction | <input type="checkbox"/> Sleepy throughout the day while working, driving or reading. Persistent tiredness. |
| <input type="checkbox"/> Unpleasant taste or breath odor | <input type="checkbox"/> Have you had a sleep study? |
| <input type="checkbox"/> Swelling, infection or bumps in mouth | <input type="checkbox"/> Oral habits (nail biting, cheek biting, etc) |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Dental anxiety |
| <input type="checkbox"/> Clenching or grinding | <input type="checkbox"/> Any bad experiences in a dental office? |
| <input type="checkbox"/> Jaw joint soreness / pain around the ear area | _____ |
| <input type="checkbox"/> Clicking or popping in the joint when eating | |

Dates of Last Dental Exam _____ Gum Disease Screening _____ Oral Cancer Screening _____

What is the primary purpose of today's visit? Any concerns?

How important is your dental health to you, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
How would you rate the appearance of your smile, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
If not a 10, please describe what you would want to improve:

How often do you brush your teeth? _____

Do you use an electric toothbrush? _____

What other dental aids do you use?

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Floss | <input type="checkbox"/> Water Pik |
| <input type="checkbox"/> Mouth rinse, which one _____ | <input type="checkbox"/> Other _____ |

Why did you leave your previous dentist? _____

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

What treatments are you interested in learning about?

- | | |
|--|--|
| <input type="checkbox"/> Orthodontics (braces) or Clear Braces | <input type="checkbox"/> Cosmetic Dentistry or Veneers |
| <input type="checkbox"/> Implants (replacing missing teeth) | <input type="checkbox"/> Teeth Whitening |
| <input type="checkbox"/> Dentures or Partial Dentures | <input type="checkbox"/> Sleep Apnea treatments |
| <input type="checkbox"/> Sedation (anxiety-free sleep dentistry) | <input type="checkbox"/> Denture Stabilization |
| <input type="checkbox"/> Gum Disease Treatments | <input type="checkbox"/> Headaches or Head/Neck/Jaw Pain |

PLEASE TURN OVER AND COMPLETE OTHER SIDE. THANK YOU.

MEDICAL HISTORY

Are you being treated by a physician now? _____ Known conditions _____
Date of last Physical Exam? _____ Physician _____
Address _____ Phone _____
City, ST, zip code _____
My Pharmacy of Choice: _____ Phone _____
Have you been hospitalized in the last 5 years? Reason? _____

IN THE FOLLOWING SECTIONS, PLEASE CHECK ALL THAT APPLY.

DO YOU HAVE OR HAVE YOU HAD A HISTORY OF:

- | | |
|--|--|
| <input type="checkbox"/> Chest pain (angina) | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Recent weight loss, fever, night sweats | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Persistent cough, coughing up blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bleeding, bruising easily | <input type="checkbox"/> Emphysema, COPD, Lung disorders |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Kidney, Bladder or Liver Disease |
| <input type="checkbox"/> Diarrhea, constipation, blood in stools | <input type="checkbox"/> Hepatitis A, B, or C |
| <input type="checkbox"/> Frequent vomiting or nausea | <input type="checkbox"/> Stomach problems, ulcers, colitis |
| <input type="checkbox"/> Difficulty urinating, blood in urine | <input type="checkbox"/> Thyroid or Adrenal Disease |
| <input type="checkbox"/> Frequent Dizziness | <input type="checkbox"/> Depression, or Anxiety Disorders |
| <input type="checkbox"/> Ringing or Pain in ears | <input type="checkbox"/> Autism, Schizophrenia, psychiatric care |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Tumors or Cancer |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Radiation or Chemotherapy treatments |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Alzheimer's or Dementia |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Parkinson's or Neuromuscular Diseases |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Eye diseases or glaucoma |
| <input type="checkbox"/> Joint pain, stiffness, arthritis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Heart disease or attack | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Valve problems | <input type="checkbox"/> Canker Sores or Cold Sore/Fever Blister |
| <input type="checkbox"/> Stroke, Stent or hardening of arteries | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Prosthetic Heart Valve | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Antibiotic pre-med prior to dental care |
| | <input type="checkbox"/> Artificial Joint or replacement |

SURGERIES: _____

ALLERGIES to medications, latex, food _____

ARE YOU TAKING ANY OF THE FOLLOWING? CHECK ALL THAT APPLY.

Yes	No	Tobacco in any form	Yes	No	Antacids
Yes	No	Alcohol	Yes	No	Consume grapefruit or grapefruit extract
Yes	No	Recreational Drugs			
Yes	No	Bisphosphonates (for Osteoporosis / Bone) such as: Fosamax, Boniva, Actonel, Zometa, or Aredia?			

Please List All Current Medications (prescription, and over-the-counter) and all Supplements

WOMEN ONLY:

Yes	No	Are you pregnant or nursing	Yes	No	Taking birth control/hormone pills
Yes	No	Have you had a hysterectomy	Yes	No	Taking fertility drugs

ALL PATIENTS:

Do you have or have you had any other diseases
or medical problems NOT listed on this form?

Yes No

If so, please explain _____

To the best of my knowledge, I have answered every question completely and accurately, I will inform my dentist of any changes in my health and/or medication.

PATIENT SIGNATURE: _____ DATE: _____