# DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? _____
Previous Dentist _____ How long have you been a patient (months/years) _____
Date of most recent dental exam _____ Date most recent x-rays _____
Date of most recent dental treatment (other than cleaning) _____
I routinely see my dentist every: _____
What is your immediate concern? _____

## Please answer yes or no to the following:

| Personal History | Yes | No |
|---|---|---|
| 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) - 10 (most) | ☐ | ☐ |
| 2. Have you had an unfavourable dental experience? | ☐ | ☐ |
| 3. Have you ever had complications from past dental treatment? | ☐ | ☐ |
| 4. Have you ever had trouble getting numb, or had any reactions to local anesthetic? | ☐ | ☐ |
| 5. Did you ever have braces, orthodontic treatment, or had your bite adjusted? | ☐ | ☐ |
| 6. Have you ever had any teeth removed? | ☐ | ☐ |
| **Smile Characteristics** | **Yes** | **No** |
| 7. Is there anything about the appearance of your teeth that you would like to change? | ☐ | ☐ |
| 8. Have you ever whitened (bleached) your teeth? | ☐ | ☐ |
| 9. Have you felt uncomfortable or self conscoius about the appearance of your teeth? | ☐ | ☐ |
| 10. Have you been disappointed with the appearance of previous dental work? | ☐ | ☐ |
| **Bite and Jaw Joint** | **Yes** | **No** |
| 11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) | ☐ | ☐ |
| 12. Do you/would you have any problems chewing gum? | ☐ | ☐ |
| 13. Do you/would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? | ☐ | ☐ |
| 14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? | ☐ | ☐ |
| 15. Are your teeth crowding or developing spaces? | ☐ | ☐ |
| 16. Do you have more than one bite and squeeze to make your teeth fit together? | ☐ | ☐ |
| 17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any oral habits? | ☐ | ☐ |
| 18. Do you clench your teeth in the daytime or make them sore? | ☐ | ☐ |
| 19. Do you have any problems with sleep or wake up with an awareness of your teeth? | ☐ | ☐ |
| 20. Do you wear or have you ever worn a bite appliance | ☐ | ☐ |
| **Tooth Structure** | **Yes** | **No** |
| 21. Have you had any cavities within the past three years? | ☐ | ☐ |
| 22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? | ☐ | ☐ |
| 23. Do you feel or notice any holes (ex: pitting, craters) on the biting surface of your teeth? | ☐ | ☐ |
| 24. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? | ☐ | ☐ |
| 25. Do you have grooves or notches on your teeth near the gumline? | ☐ | ☐ |
| 26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? | ☐ | ☐ |
| 27. Do you frequently get food caught between any teeth? | ☐ | ☐ |
| **Gum and Bone** | **Yes** | **No** |
| 28. Do your gums bleed or are they painful when brushing or flossing? | ☐ | ☐ |
| 29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? | ☐ | ☐ |
| 30. Have you ever noticed an unpleasant taste or odour in your mouth? | ☐ | ☐ |
| 31. Is there anyone with a history of periodontal disease in your family? | ☐ | ☐ |
| 32. have you ever experienced gum recession? | ☐ | ☐ |
| 33. Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple? | ☐ | ☐ |
| 34. Have you experienced a burning sensation in your mouth? | ☐ | ☐ |

Patient's Signature _____

Doctor's Signature _____

# MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

| DO YOU HAVE OR HAVE YOU EVER HAD: | YES | NO |
|---|---|---|
| 1. Hospitalization for illness or injury _____ | ☐ | ☐ |
| 2. An allergic reaction to _____ | ☐ | ☐ |
| Aspirin, ibuprofen, acetaminophen, codeine | | |
| penicillin | | |
| tetracycline | | |
| sulfa | | |
| local anesthetic | | |
| nickel | | |
| latex | | |
| other | | |
| 3. heart problems or cardiac stent within the last 6 months | ☐ | ☐ |
| 4. history of infective endocarditis _____ | ☐ | ☐ |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | ☐ | ☐ |
| 6. pacemaker or implantable defibrilator _____ | ☐ | ☐ |
| 7. artifical prosthesis (heart valve or joints) _____ | ☐ | ☐ |
| 8. rheumatic or scarlet fever _____ | ☐ | ☐ |
| 9. high or low blood disorder (pressure) _____ | ☐ | ☐ |
| 10. a stroke (taking blood thinners) _____ | ☐ | ☐ |
| 11. anemia or other blood disorder _____ | ☐ | ☐ |
| 12. prolonged bleeding due to slight cut (INR>3.5) _____ | ☐ | ☐ |
| 13. emphysema, sarcoidosis _____ | ☐ | ☐ |
| 14. tuberculosis _____ | ☐ | ☐ |
| 15. asthma _____ | ☐ | ☐ |
| 16. breathing or sleep problems (ex: snoring, sinus) | ☐ | ☐ |
| 17. kidney disease _____ | ☐ | ☐ |
| 18. liver disease _____ | ☐ | ☐ |
| 19. jaundice _____ | ☐ | ☐ |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | ☐ | ☐ |
| 21. hormone deficiency _____ | ☐ | ☐ |
| 22. high cholesterol or taking statin drugs _____ | ☐ | ☐ |
| 23. disabetes (HbA1c=) _____ | ☐ | ☐ |
| 24. stomach or duodenal ulcer _____ | ☐ | ☐ |
| 25. digestive disorders (ex: gastric reflux) _____ | ☐ | ☐ |
| 26. osteoperosis/osteopenia _____ | ☐ | ☐ |
| (ex: taking bisphosphonates) _____ | ☐ | ☐ |
| 27. arthritis _____ | ☐ | ☐ |
| 28. glaucoma _____ | ☐ | ☐ |
| 29. contact lenses _____ | ☐ | ☐ |
| 30. head or neck injuries _____ | ☐ | ☐ |
| 31. epilepsy, convulsion (seizures) _____ | ☐ | ☐ |
| 32. neurologic problems (attention deficit disorder) | ☐ | ☐ |
| 33. viral infections and cold sores _____ | ☐ | ☐ |
| 34. any lumps or swelling in the mouth _____ | ☐ | ☐ |
| 35. hives, skin rash, hay fever _____ | ☐ | ☐ |
| 36. hepatitis (type) _____ | ☐ | ☐ |
| 37. HIV/AIDS _____ | ☐ | ☐ |
| 38. tumor, abnormal growth _____ | ☐ | ☐ |
| 39. radiation therapy _____ | ☐ | ☐ |
| 40. chemotherapy _____ | ☐ | ☐ |
| 41. emotional problems _____ | ☐ | ☐ |
| 42. psychiatric treatment _____ | ☐ | ☐ |
| 43. antidepressant medication _____ | ☐ | ☐ |
| 44. alcohol/street drug use _____ | ☐ | ☐ |
| **ARE YOU:** | | |
| 45. presently being treated for any other illness _____ | ☐ | ☐ |
| 46. aware of a change in your health (ex: fever, cough) | ☐ | ☐ |
| 47. taking medications _____ | ☐ | ☐ |
| 48. taking dietary supplements _____ | ☐ | ☐ |
| 49. often exhausted or fatigued _____ | ☐ | ☐ |
| 50. experiencing frequent headaches _____ | ☐ | ☐ |
| 51. a smoker, smoked previously or use smokeless tobacco | ☐ | ☐ |
| 52. considered a touchy person _____ | ☐ | ☐ |
| 53. often unhappy or depressed _____ | ☐ | ☐ |
| 54. FEMALE - pregnant _____ | ☐ | ☐ |
| 55. MALE - prostate disorder _____ | ☐ | ☐ |

Describe any current treatment, impending surgery, or other treatment that may possibly affect your dental treatment (ex: Botox, Collagen injections)

_____

_____

List all medications, supplements, and/or vitamins taken within the last two years.

| DRUGS | PURPOSE | DRUGS | PURPOSE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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Patient's Signature _____

Doctor's Signature _____