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

Information gathered in this form will be used only under the Gallery Dental Privacy Policy guidelines for the collection of personal information.

Patient's Signature _____

Doctor's Signature _____