

Dental History

Name: _____

Date of last dental visit: _____ Name of last Dentist: _____

***Please answer yes or no to the following questions. If yes, please explain.

In case of an emergency, please contact: _____ Phone _____

Dental:

1. What is your chief concern? _____
2. Are you apprehensive about dental treatment? _____
Explain: _____
3. Have you had problems with previous dental treatment? _____
Explain: _____
4. Does food catch between your teeth? _____
If so, where? _____
5. Do you have difficulty chewing your food? _____
6. Do you chew on only one side of your mouth? _____
7. Do you have any broken teeth or broken fillings? _____
8. Do you avoid brushing any part of your mouth because of pain? _____
If so, where? _____
9. Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____
10. Do you take fluoride supplements? _____
11. Have you ever noticed slow healing sores in or about your mouth? _____
12. Are your teeth sensitive to: Hot _____ Cold _____ Sour _____ Sweet _____ Hard Foods? _____
13. Are you dissatisfied with the appearance of your teeth? _____
If so, why? _____
14. Do you gag easily? _____
15. Do you wear dentures? _____ or partials? _____. If yes, when were they made? _____

Gum Disease:

1. Do your gums bleed easily when you Brush? _____ Floss? _____
2. Do your gums feel swollen or tender? _____
3. How often do you brush? _____. Floss? _____
4. Do you use any other oral hygiene aids? _____ If so, what: _____
5. Have you ever had periodontal treatment? _____ If so, when: _____
6. Do you have an unpleasant taste in your mouth? _____

Orthodontics:

1. Do you feel your bite is uncomfortable? _____ Irregular? _____ Undesirable? _____
2. Have your teeth ever been straightened? _____ If so, when: _____
3. Have you ever had an orthodontic appliance? _____ If so what: _____

TMJ:

1. Have you ever been treated for TMJ? _____ If so, When: _____
2. Do you clench or grind your teeth frequently? _____ Do you have a nightguard? _____
3. Do you have earaches or pain in your ears, face, cheek, jaw, joints, throat, or temples? _____
Explain: _____
4. Does your jaw make noise, feel tired, get stuck, hurt, or has it been injured in any way? _____
Explain: _____
5. Are you unable to open your mouth as far as you want? _____
6. Are you a chronic gum chewer? _____
7. How often do you have headaches? Per day: _____ Per Week: _____ Per Month: _____

Other Information

Date of Last Dental Visit: _____

Patient Name _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

Heart Problems, Chest pain, Shortness of breath, Blood pressure High, Low? _____

Explain _____

Heart murmur, Rheumatic fever, Angina or Taking heart medications? _____

Explain _____

Heart valve problem, Pacemaker or Artificial heart valve? _____

Explain _____

Stroke? _____

Joint replacement (total hip, pins, or implants)? _____

Premedications required by physician? _____

Blood problems, Easy bruising, Frequent nose bleeds, Abnormal bleeding? _____

Explain _____

Blood disease (anemia) or Ever require a blood transfusion? _____

Explain _____

Allergy problems, Hay fever, Sinus problems or Skin rash? _____

Explain _____

Intestinal problems, Ulcers, Weight gain or loss, Special diet? _____

Explain _____

Kidney or bladder problems? _____

Bone or joint problems, Arthritis, Back or neck pain? _____

Fainting spells, seizures, neurological disease or epilepsy? _____

Frequent or severe headaches? _____

Thyroid problems? _____

Persistent cough or swollen glands? _____

Diabetes, Frequent urination or Dry mouth and frequent thirst? _____

Family history of diabetes? _____

Tuberculosis, Asthma or other respiratory disease? _____

Cancer or tumor? _____

Do you drink alcohol, Smoke or have a history of substance abuse? _____

If so, explain? _____

Hepatitis, A, B, C ,jaundice or liver trouble? _____

Herpes, HIV, AIDS or a Sexually Transmitted disease? _____

Glaucoma or Do you wear contacts? _____

History of head injury? _____

HAVE YOU HAD AN ALLERGIC REACTION TO ANY OF THE FOLLOWING

Local anesthetics, Penicillin or other antibiotics, Sulfa, Aspirin, Metals _____

Acetaminophen, Ibuprofen, Codeine, Iodine, Latex or other? _____

Explain _____

During the last 12 months what medications have you taken?

List _____

List _____

Do you have any problem not listed previously that we should know about? _____

If so, please describe: _____

Patient/Guardian Signature Date _____

For women only: Are you pregnant or nursing? _____

Delivery date: _____