SHELLY MCAVOY, D.M.D.

COOPER CREEK DENTAL
Where you're more than a patient

ANN MOONEY, D.M.D.

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# DENTAL HISTORY

Name _____ Date of Birth _____

**WHEN WAS YOUR LAST:** Dental Exam? _____ Cleaning? _____

Dental X-Rays? _____ Oral Cancer Screening? _____

Why did you leave your previous dentist? _____

Name of Previous Dentist _____ City _____ State _____

**SENSITIVITY/DISCOMFORT OF YOUR TEETH:**

Are you having any PAIN/DISCOMFORT? _____

Where? UR LR UL LL

Rate your current pain from 1 - 10, with 10 being most painful:

1 2 3 4 5 6 7 8 9 10

| | Yes | No |
|---|---|---|
| Do you have CHIPPED, BROKEN, OR CRACKED Teeth? | ☐ | ☐ |
| Do you have any SENSITIVITY to: | | |
| HOT? | ☐ | ☐ |
| COLD? | ☐ | ☐ |
| SWEETS? | ☐ | ☐ |
| Are you anxious/nervous upon coming to the dentist office? | ☐ | ☐ |
| Do you use Sensitive Toothpaste? | ☐ | ☐ |
| Do you use Home Fluoride? | ☐ | ☐ |
| Does your mouth get DRY? | ☐ | ☐ |

**HOME CARE:**

| | | |
|---|---|---|
| Do you use an Electric Toothbrush? | ☐ | ☐ |
| What Brand? _____ | | |
| Do you use a manual toothbrush? | ☐ | ☐ |
| Do you use soft, medium, or hard bristles? _____ | | |

How often do you brush? _____ times per day

How often do you floss? _____ times per day

Are you concerned about bad breath? ☐ ☐

**HABITS:**

| | | |
|---|---|---|
| Do you smoke or use chewing tobacco? | ☐ | ☐ |
| How much? _____ For how long? _____ | | |
| Do you drink? | ☐ | ☐ |
| How much? _____ # of drinks per week _____ | | |

| | Yes | No |
|---|---|---|
| **CONTACT/NON-CONTACT SPORTS:** | | |
| Are you involved? | ☐ | ☐ |
| List sport(s) _____ | | |
| Have you ever worn a mouthguard or Athletic guard? | ☐ | ☐ |
| Have you ever worn Sports Enhancement appliances? | ☐ | ☐ |
| **TMJ:** | | |
| Do you have Headaches, Earaches, or Neck Pain? | ☐ | ☐ |
| Do you have Jaw Joint/TMJ Paint? | ☐ | ☐ |
| Do you Grind or Clench your teeth? | ☐ | ☐ |
| Have you ever had Orthodontic Treatment? | ☐ | ☐ |
| If yes, do you have an Orthodontic Retainer? | ☐ | ☐ |
| Do you have a Night Guard? | ☐ | ☐ |
| How often do you wear it? _____ | | |
| **PROSTHODONTICS:** | | |
| Do you have or have you had any of the following? | | |
| Removable Dentures? | ☐ | ☐ |
| Removable Partial Dentures? | ☐ | ☐ |
| **PERIODONTAL HISTORY:** | | |
| Do you have Bleeding, Swollen, or Irritated gums? | ☐ | ☐ |
| Do you have Loose, Tipped, or Shifting teeth? | ☐ | ☐ |
| Have you ever had Periodontal (gum) treatments? | ☐ | ☐ |
| Have you ever had Periodontal/Deep Cleanings? | ☐ | ☐ |
| **ESTHETICS:** | | |
| If you could easily whiten your teeth, would you do it? | ☐ | ☐ |

If I could change my smile, I would: (check all that apply)

- Make them Whiter_____
- Make them Straighter_____
- Close Spaces_____
- Replace black metal fillings with Tooth Colored Restorations_____
- Repair chipped teeth_____
- Replace missing teeth_____
- Replace old crowns that don't match_____
- Have a Smile Makeover_____

**ON A SCALE FROM 1 -10 WITH 10 BEING THE HIGHEST RATING:**

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

How would you rate your dental health now?

1 2 3 4 5 6 7 8 9 10

Where you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental work? _____

What is the most important thing to you about your dental visit today? _____

What can we do to make your visit more comfortable? _____

Patient Signature _____ Date _____

# MEDICAL HISTORY

Name _____ Date of Birth _____

Physician's Name _____ Physician's Phone # _____

Have you ever needed to take antibiotics prior to dental work? Yes_____ No_____ Why? _____

Do you take antibiotics now prior to dental work What? _____

**Do you have or have you ever had the following:**

**CARDIOLOGY:**

| | Yes | No |
|---|---|---|
| Angina/Chest Pain? | ☐ | ☐ |
| Heart Lesions or Abnormalities? | ☐ | ☐ |
| Please explain _____ | | |
| Do you have Heart Murmur? | ☐ | ☐ |
| Was it detected at birth? | ☐ | ☐ |
| High Blood Pressure? | ☐ | ☐ |
| Low Blood Pressure? | ☐ | ☐ |
| Defibrillator or Pacemaker? When _____ | ☐ | ☐ |
| Stroke? | ☐ | ☐ |
| Heart Surgery | ☐ | ☐ |
| If yes, when? _____ Type? _____ | | |
| Do you take Coumadin, Warafin, Plavix? INR? | ☐ | ☐ |
| Do you take a baby Aspirin daily? | ☐ | ☐ |
| Other Heart Conditions? | ☐ | ☐ |
| Please explain _____ | | |
| Name of Cardiologist _____ | | |
| Phone # _____ | | |

**BLOOD DISORDERS:**

| | | |
|---|---|---|
| Anemia? | ☐ | ☐ |
| Do you bruise easily? | ☐ | ☐ |
| Excessive bleeding? | ☐ | ☐ |
| Other types of Blood Disorders? | ☐ | ☐ |
| If yes, please describe _____ | | |

**CANCER:**

| | | |
|---|---|---|
| Human Papilloma Virus (HPV)? | ☐ | ☐ |
| Head, Neck or Oral Cancer? | ☐ | ☐ |
| Other types of Cancer? Please list below | ☐ | ☐ |
| _____ | | |
| Was it removed by Surgery? | ☐ | ☐ |
| Have you had Chemotherapy? | ☐ | ☐ |
| When? _____ | | |
| Have you ever had Radiation Therapy? | ☐ | ☐ |
| When? _____ | | |

**LIVER DISEASE:**

| | | |
|---|---|---|
| Hepatitis? Type? _____ | ☐ | ☐ |
| Other Liver Disorders? _____ | ☐ | ☐ |

**WOMEN ONLY:**

| | | |
|---|---|---|
| Are you Pregnant? | ☐ | ☐ |
| What Trimester are you in? _____ | | |
| Are you breast feeding? | ☐ | ☐ |
| Do you take Birth Control Pills? | ☐ | ☐ |

**NEUROLOGY/PSYCHOLOGY:**

| | Yes | No |
|---|---|---|
| Alzheimer's? | ☐ | ☐ |
| Seizures? | ☐ | ☐ |
| Fainting? | ☐ | ☐ |
| Nervousness? | ☐ | ☐ |
| Depression? | ☐ | ☐ |
| Anxiety? | ☐ | ☐ |
| Other? _____ | ☐ | ☐ |

**RESPIRATORY:**

| | | |
|---|---|---|
| Allergies? | ☐ | ☐ |
| Asthma? | ☐ | ☐ |
| Emphysema or COPD? | ☐ | ☐ |
| Other? _____ | ☐ | ☐ |

**MISCELLANEOUS:**

| | | |
|---|---|---|
| AIDS or HIV? | ☐ | ☐ |
| Arthritis? | ☐ | ☐ |
| Type? _____ | | |
| Artificial Joints? | ☐ | ☐ |
| When? _____ Type? _____ | | |
| Diabetes? | ☐ | ☐ |
| Alcohol Addiction? | ☐ | ☐ |
| Drug Addiction? | ☐ | ☐ |
| Tuberculosis? | ☐ | ☐ |
| Gastric Reflux? | ☐ | ☐ |
| Thyroid Disease? | ☐ | ☐ |
| Are you taking any medications for osteoporosis (bisphosphonates)? | ☐ | ☐ |
| What? _____ | | |
| How long are/were you taking it? _____ | | |
| Do you have any other disease, problem or condition not listed above? | ☐ | ☐ |
| Please explain _____ | | |
| _____ | | |
| Allergy to Latex? | ☐ | ☐ |

**ALLERGIES TO MEDICATIONS:**
(i.e. Rash, Itching/Swelling)

_____

_____

_____

**PLEASE LIST ALL MEDICATIONS THAT YOU TAKE AND REASON YOU TAKE THEM:**

_____

_____

_____

**AUTHORIZATION AND RELEASE**

I understand that this information will be held in the strictest confidence and it is my responsibility to inform Cooper Creek Dental of any changes in my medical status. I acknowledge that this information is true and I understand not being forthcoming with information may impede, hinder, or contraindicate my dental treatment and I will not hold the dentist liable for my misrepresentation of information. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. Upon diagnosis, I authorize the dentist to give me all treatment options so I can make an informed decision. I authorize the dentist to perform the needed treatment and administer or prescribe any necessary medication.

Patient/Guardian Signature _____ Date _____

Dental Signature _____ Date _____