Dental History

Patient Name _____ Age _____ Date _____
Reason for seeking care today: _____ Exam _____ Cleaning _____ Specific Problem _____

Please check all that apply:

_ Toothache
_ Broken filling or tooth
Sensitivity to:
_ Cold
_ Hot
_ Sweets
_ Chewing
_ Food catches
_ Loose teeth

_ Bite or teeth have shifted
_ Frequent dry mouth
_ Concerned about breath
_ Unhappy with previous dental work
_ Clench or grind teeth
_ Cold sores, fever blisters
_ Previous gum treatment

_ Bad taste in mouth
_ Sinus problems
_ Gums bleed
_ Gums tender
_ Growths, sores
_ Bite fingernails
_ Jaw joint pain
_ Wore braces

_ Unable to open mouth wide
_ Jaw gets tired easily
_ Shoulder, neck or headaches
_ Hold things between teeth (pipe, pencil, nails, pins)
_ Clicking or popping of joint
_ Unusual habits with teeth
_ Previous bite treatment

Would you like whiter teeth? _____ Do you have bad breath (halitosis) concerns? _____
Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?

Please rate 1 – 10 how anxious you are about dental treatment (1= totally relaxed) _____
Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____
What happened? _____
Why did you leave your previous dentist? _____

Medical History

Physicians Name _____Phone #_____
Have you been hospitalized for any reason? Please describe:

_____
_____

Are you taking any medications or drugs (including nutritional supplements?) Please list:

_____
_____
_____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other? _____
_____

Do you smoke? How much/day? _____
Are you seeing a physician now or planning to see one for any reason? Please explain:

_____
_____

Women Only: Are you pregnant? ____ Due Date: _____

Please check all that apply:

_ Previous injury to head or neck
_ Heart problem
_ Angina, chest pain
_ Angina, chest pain
_ Heart murmur
_ Scarlet, rheumatic fever
_ Mitral valve prolapse
_ Irregular heartbeat
_ High or low blood pressure
_ Pacemaker
_ Artificial joint

_ Diabetes
_ Kidney problem
_ Liver problem, jaundice
_ Cirrhosis, Hepatitis
_ Cancer
_ Radiation, chemo.
_ Respiratory problem
_ Asthma, Emphysema
_ HIV or AIDS
_ Sickle cell
_ Dry eyes

_ Digestive problem, ulcer
_ Thyroid disease
_ Glaucoma
_ Bleed or bruise easily
_ Unexplained weight loss
_Epilepsy or Seizures
_ Drug or alcohol addiction
_ 2 or more social drinks/day
_ Anxiety or nervous disorder
_ Insomnia
_ Anemia

_ Shortness of breath
_ Snoring, sleep apnea
_ No energy
_ Fainting or dizzy
_ Stroke
_ Chewing tobacco
_ Parkinson's
_ Alzheimer's
_ Back problem
_ Hives, rash, Herpes

Any other illnesses not checked above: _____
Please indicate if you would prefer to speak privately with the dentist about a medical issue: ___ Yes ___ No
Please rate your daily stress level: 1 – 10 (1 = lowest stress).
___ Overworked, busy, pressured ___ Worried, frustrated ___ Get upset or snap easily ___ Insomnia, depression, anxiety

I will inform this office of any changes in my health status. I certify that the above information is complete and accurate to the best of my knowledge. I hereby consent to treatment to be performed in this office, and I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. Furthermore, I understand that possible complications may occur from a proposed treatment and that a perfect result cannot be guaranteed.

Patient Signature (parent or guardian) _____ Date _____

Dentist Signature _____ Date _____