

Dental History

Patient Name _____ Age _____ Date _____

Reason for seeking care today: _____ Exam _____ Cleaning _____ Specific Problem _____

Please check all that apply:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Bite or teeth have shifted | <input type="checkbox"/> Bad taste in mouth | <input type="checkbox"/> Unable to open mouth wide |
| <input type="checkbox"/> Broken filling or tooth | <input type="checkbox"/> Frequent dry mouth | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Jaw gets tired easily |
| Sensitivity to: | <input type="checkbox"/> Concerned about breath | <input type="checkbox"/> Gums bleed | <input type="checkbox"/> Shoulder, neck or headaches |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Unhappy with previous dental work | <input type="checkbox"/> Gums tender | <input type="checkbox"/> Hold things between teeth (pipe, pencil, nails, pins) |
| <input type="checkbox"/> Hot | <input type="checkbox"/> Clench or grind teeth | <input type="checkbox"/> Growths, sores | <input type="checkbox"/> Clicking or popping of joint |
| <input type="checkbox"/> Sweets | <input type="checkbox"/> Cold sores, fever blisters | <input type="checkbox"/> Bite fingernails | <input type="checkbox"/> Unusual habits with teeth |
| <input type="checkbox"/> Chewing | <input type="checkbox"/> Previous gum treatment | <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Previous bite treatment |
| <input type="checkbox"/> Food catches | | <input type="checkbox"/> Wore braces | |
| <input type="checkbox"/> Loose teeth | | | |

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:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Previous injury to head or neck | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive problem, ulcer | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Heart problem | <input type="checkbox"/> Kidney problem | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Snoring, sleep apnea |
| <input type="checkbox"/> Angina, chest pain | <input type="checkbox"/> Liver problem, jaundice | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> No energy |
| <input type="checkbox"/> Angina, chest pain | <input type="checkbox"/> Cirrhosis, Hepatitis | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Fainting or dizzy |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Cancer | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Scarlet, rheumatic fever | <input type="checkbox"/> Radiation, chemo. | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Chewing tobacco |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Respiratory problem | <input type="checkbox"/> Drug or alcohol addiction | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Asthma, Emphysema | <input type="checkbox"/> 2 or more social drinks/day | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Anxiety or nervous disorder | <input type="checkbox"/> Back problem |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sickle cell | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Hives, rash, Herpes |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Anemia | |

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 _____