

Patient Background Data (Medical/Dental History)

- PURPOSE:** Obtain pertinent social-family, dental, and medical history essential to complete diagnosis and treatment planning.
- All patient information is kept strictly confidential, and will not be disclosed without the patient's written permission

PRESENT DENTAL NEEDS

1. The main reason for my dental appointment is: Routine examination and Treatment Emergency examination and Treatment Consultation and/or second opinion

2. My main dental problem now is: _____

3. Please check what you feel are your present dental needs (check as many as applicable):

Based on: Past Dental Exam: (Date: _____) Patient's opinion only

Date of Last Teeth Cleaning: _____

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Emergency: | <input type="checkbox"/> Pain | <input type="checkbox"/> Swelling | |
| | <input type="checkbox"/> Broken Tooth | <input type="checkbox"/> Lost Filling | |
| <input type="checkbox"/> Root Canal | <input type="checkbox"/> Front Tooth | <input type="checkbox"/> Back Tooth | |
| <input type="checkbox"/> Extractions | | | |
| <input type="checkbox"/> Gum Treatment: | <input type="checkbox"/> Routine Cleaning of Teeth | <input type="checkbox"/> Deep Cleaning (Scaling and Root Planing) | <input type="checkbox"/> Gum Surgery |
| <input type="checkbox"/> Fillings: | <input type="checkbox"/> Front Teeth | <input type="checkbox"/> Back Teeth | |
| <input type="checkbox"/> Crowns (Caps): | <input type="checkbox"/> Front Teeth | <input type="checkbox"/> Back Teeth | |
| <input type="checkbox"/> Cosmetic Dentistry (whitening/bonding /veneers) | | | |
| <input type="checkbox"/> Orthodontics (Braces) | | | |
| <input type="checkbox"/> Replace Some Missing Teeth: | <input type="checkbox"/> Removable partial Denture may be taken out by patient) | <input type="checkbox"/> Fixed Bridge (Permanently Cemented) | |
| <input type="checkbox"/> Full Dentures (Replaces all teeth) | | | |
| <input type="checkbox"/> Implants | | | |

5. How satisfied have you been with your previous dental care? Satisfied Indifferent Unsatisfied
6. Do you fear receiving dental care? Not at all afraid Somewhat afraid Very afraid
7. Have you ever avoided dental care because you expect pain or discomfort? Never Occasionally Frequently
8. How important to you is the way your teeth look? Very Important Somewhat Important Unimportant

9. Please check (all that apply) if you **now** have:

- | | | |
|---|---|--|
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Pain or ringing in ears | <input type="checkbox"/> Habit of mouth breathing |
| <input type="checkbox"/> Stain on teeth | <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Tartar (calculus) build-up | <input type="checkbox"/> Difficulty opening your mouth wide | <input type="checkbox"/> Sensitive teeth |
| <input type="checkbox"/> Gum shrinkage | <input type="checkbox"/> Habit of clenching or grinding | <input type="checkbox"/> Unpleasant breath |
| <input type="checkbox"/> Headache/Neckaches/Shoulderaches | <input type="checkbox"/> Popping or clicking in jaw joints | <input type="checkbox"/> Incomplete dental treatment |
| | <input type="checkbox"/> Fatigue in face or jaws when you awake | <input type="checkbox"/> Other |

10. Please check (all that apply) if you **have ever** had:

- | | | |
|--|--|---|
| <input type="checkbox"/> Gum surgery | <input type="checkbox"/> Trauma to head or jaw | <input type="checkbox"/> Nitrous Oxide (laughing gas) |
| <input type="checkbox"/> Deep cleaning of gums (scaling/root planing) | <input type="checkbox"/> Orthodontics (braces or retainer) | <input type="checkbox"/> Bad reaction to local anesthetic |
| <input type="checkbox"/> Teeth lost due to gum disease | <input type="checkbox"/> Root canal treatment | <input type="checkbox"/> Slow healing sore in mouth/on lips |
| <input type="checkbox"/> Teeth lost for other reasons | | |
| <input type="checkbox"/> Complications following dental treatment. Please explain: _____ | | |

ESTHETIC EVALUATION

Please circle the appropriate answer

	YES					NO				
Are you satisfied with your teeth and their appearance?	5	4	3	2	1	5	4	3	2	1
Are you self-conscious about your teeth when you smile?	5	4	3	2	1	5	4	3	2	1
Do you ever cover your smile with your hand?	5	4	3	2	1	5	4	3	2	1
Do you wish your teeth were whiter?	5	4	3	2	1	5	4	3	2	1
Do you wish your teeth were shaped differently?	5	4	3	2	1	5	4	3	2	1
Do you have any discolored teeth?	5	4	3	2	1	5	4	3	2	1
Have esthetic dental procedures ever been recommended to you?	5	4	3	2	1	5	4	3	2	1

OCCLUSAL SCREENING

	YES	NO
1. Do you clench or grind your teeth during the day?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been made aware of clenching or grinding your teeth during the night?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have chronic headaches, or neck and shoulder pains?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are your jaws or teeth tired when you awaken?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you now, or have you ever had, pain in your jaw joint or the sides of your face (in and about the ears)	<input type="checkbox"/>	<input type="checkbox"/>
6. Have your jaws ever clicked or popped when you open your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced difficulty moving your jaw or opening your mouth wide?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>

DENTURES

	YES	NO
Do any of your family, including your parents, wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>
How many dentures do you wear? _____		
How long have you worn dentures? _____		
Why were your teeth extracted? _____		
If you are currently having a denture problem, is it related to:		
Pain <input type="checkbox"/> Discomfort <input type="checkbox"/> Appearance <input type="checkbox"/> Function <input type="checkbox"/>		
How did you feel about getting dentures? _____		

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his Staff, and assume financial responsibility.

Signature _____ Date _____
Parent if patient is a minor

Received & witnessed by _____ Date _____ Reviewed by Dr. _____ Date _____

Name of physician _____ City _____ Ph _____

Do you have a current medical problem? Yes No What? _____

Have you ever had any of the following:

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Lung disease (TB, asthma, emphysema) | <input type="checkbox"/> | <input type="checkbox"/> | Cancer (radiation, chemotherapy) |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease (hepatitis A, B, or C, Jaundice) | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune disease | <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV, AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Problem | <input type="checkbox"/> | <input type="checkbox"/> | Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions or Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina (pain, tightness in chest) | <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease (Leukemia) |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion What Year? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heart Beat | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Stomach/Ulcers/Intestinal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Taken Fen Phen? or Redux |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling of ankles or feet | <input type="checkbox"/> | <input type="checkbox"/> | Bisphosphonates (Boniva, Fosamax, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Psychotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent cough | <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision changes | <input type="checkbox"/> | <input type="checkbox"/> | Hives/Rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Hearing | <input type="checkbox"/> | <input type="checkbox"/> | Numbness or Tingling |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurological disorders (MS, MD, ALS) | | | |

Are you now:

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnant or nursing a child | <input type="checkbox"/> | <input type="checkbox"/> | Using Dilantin |
| <input type="checkbox"/> | <input type="checkbox"/> | Using thyroids | <input type="checkbox"/> | <input type="checkbox"/> | Using other medicines |
| <input type="checkbox"/> | <input type="checkbox"/> | Using hormones (birth control pills) | | | Medicine for _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Using anticoagulents | | | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you need an antibiotic "pre-medication" prior to dental appointments? | | | |
| | | If so, for what condition do you pre-medicate and what antibiotic do you take? _____ | | | |
| | | | | | _____ |

Are you now taking or using medicines for:

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (pills or shot) | <input type="checkbox"/> | <input type="checkbox"/> | Allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | Nerves (tranquilizers) | <input type="checkbox"/> | <input type="checkbox"/> | Blood (iron pills, blood thinners) |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleeping | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart or blood pressure
(digitalis, nitroglycerin, resorpin) | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis or rheumatism |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Headaches |

Have you ever been sick from, shown an allergy to, or told not to take:

- | | | | | | |
|--------------------------|--------------------------|------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Novacaine |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain medications | <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Narcotic Drugs | <input type="checkbox"/> | <input type="checkbox"/> | Other drugs or medicines |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Have you ever had a major operation? No Yes What Kind? _____

Have you ever been involved in a serious accident? No Yes Describe: _____

Comments: _____
