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**Patient Full Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**DENTAL HISTORY**

*Please check the appropriate boxes if you currently have, or have experienced:*

- |  |   |
|--|---|
| <input type="checkbox"/> Tooth sensitivity hot, cold, or sweets        | <input type="checkbox"/> Burning tongue   |
| <input type="checkbox"/> Tooth pain when chewing or biting             | <input type="checkbox"/> Previous orthodontic (braces) treatment  |
| <input type="checkbox"/> Cracked or Chipped teeth                      | <input type="checkbox"/> Wear a removable dental appliance  |
| <input type="checkbox"/> Bleeding gums, How long? _____                | <input type="checkbox"/> Mouth breathing or Dry mouth   |
| <input type="checkbox"/> Pain or soreness in gums                      | <input type="checkbox"/> Do you snore?  |
| <input type="checkbox"/> Food impaction                                | <input type="checkbox"/> Sleepy throughout the day while working, driving or reading. Persistent tiredness. |
| <input type="checkbox"/> Unpleasant taste or breath odor               | <input type="checkbox"/> Have you had a sleep study?  |
| <input type="checkbox"/> Swelling, infection or bumps in mouth         | <input type="checkbox"/> Oral habits (nail biting, cheek biting, etc)                                       |
| <input type="checkbox"/> Loose teeth                                   | <input type="checkbox"/> Dental anxiety   |
| <input type="checkbox"/> Clenching or grinding                         | <input type="checkbox"/> Any bad experiences in a dental office?  |
| <input type="checkbox"/> Jaw joint soreness / pain around the ear area | _____   |
| <input type="checkbox"/> Clicking or popping in the joint when eating  |   |

Dates of Last Dental Exam \_\_\_\_\_ Gum Disease Screening \_\_\_\_\_ Oral Cancer Screening \_\_\_\_\_

What is the primary purpose of today's visit? Any concerns? \_\_\_\_\_  
\_\_\_\_\_

How important is your dental health to you, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10  
Where would you rate your current dental health, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10  
How would you rate the appearance of your smile, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10  
If not a 10, please describe what you would want to improve: \_\_\_\_\_  
\_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

Do you use an Electric Toothbrush? \_\_\_\_\_

What other dental aids do you use?

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Floss                        | <input type="checkbox"/> Water Pik   |
| <input type="checkbox"/> Mouth rinse, which one _____ | <input type="checkbox"/> Other _____ |

Why did you leave your previous dentist?  
\_\_\_\_\_

If you could whiten your teeth for a cost anyone could afford, would you do it? \_\_\_\_\_

What treatments are you interested in learning about?

- |  |  |
|--|--|
| <input type="checkbox"/> Orthodontics (braces) or Clear Braces   | <input type="checkbox"/> Cosmetic Dentistry or Veneers   |
| <input type="checkbox"/> Implants (replacing missing teeth)      | <input type="checkbox"/> Teeth Whitening                 |
| <input type="checkbox"/> Dentures or Partial Dentures            | <input type="checkbox"/> Sleep Apnea treatments          |
| <input type="checkbox"/> Sedation (anxiety-free sleep dentistry) | <input type="checkbox"/> Denture Stabilization           |
| <input type="checkbox"/> Gum Disease Treatments                  | <input type="checkbox"/> Headaches or Head/Neck/Jaw Pain |

**PLEASE TURN OVER AND COMPLETE OTHER SIDE. THANK YOU.**

**MEDICAL HISTORY**

Are you being treated by a physician now? \_\_\_\_\_ For what? \_\_\_\_\_

Date of last Physical Exam? \_\_\_\_\_

Name of Physician \_\_\_\_\_ Address \_\_\_\_\_

Physician's Phone \_\_\_\_\_ City \_\_\_\_\_

My Pharmacy of Choice: \_\_\_\_\_ Phone # \_\_\_\_\_

Have you been hospitalized in the last 5 years? For what? \_\_\_\_\_

**HAVE YOU EXPERIENCED:**

Yes	No	Chest pain (angina)	Yes	No	Frequent Dizziness
Yes	No	Swollen ankles	Yes	No	Ringing or Pain in ears
Yes	No	Recent weight loss, fever, night sweats	Yes	No	Frequent Headaches
Yes	No	Persistent cough, coughing up blood	Yes	No	Blurred vision
Yes	No	Bleeding problems, bruising easily	Yes	No	Seizures
Yes	No	Sinus problems	Yes	No	Excessive thirst
Yes	No	Difficulty swallowing	Yes	No	Frequent urination
Yes	No	Diarrhea, constipation, blood in stools	Yes	No	Dry mouth
Yes	No	Frequent vomiting or nausea	Yes	No	Jaundice
Yes	No	Difficulty urinating, blood in urine	Yes	No	Joint pain, stiffness, arthritis

**DO YOU HAVE OR HAVE YOU HAD:**

Yes	No	Heart disease, or attack	Yes	No	Autism, Schizophrenia, psychiatric care
Yes	No	Heart murmur	Yes	No	Tumors or Cancer
Yes	No	Rheumatic fever	Yes	No	Radiation or Chemotherapy treatments
Yes	No	Heart Valve problems	Yes	No	Alzheimers or Dementia
Yes	No	Stroke, Stent or hardening of arteries	Yes	No	Parkinson's or Neuromuscular Diseases
Yes	No	Prosthetic Heart Valve	Yes	No	HIV Positive
Yes	No	High blood pressure	Yes	No	AIDS
Yes	No	High Cholesterol	Yes	No	Eye diseases or glaucoma
Yes	No	Pacemaker	Yes	No	Sleep Apnea
Yes	No	Diabetes	Yes	No	Skin diseases
Yes	No	Asthma	Yes	No	Anemia
Yes	No	Emphysema, COPD, Lung disorders	Yes	No	Venereal Disease
Yes	No	Tuberculosis	Yes	No	Canker Sores or Cold Sore/Fever Blister
Yes	No	Kidney, Bladder or Liver Disease	Yes	No	Hospitalization
Yes	No	Hepatitis A, B, or C	Yes	No	Blood transfusions
Yes	No	Stomach problems, ulcers, colitis	Yes	No	Antibiotic pre-med prior to dental care
Yes	No	Thyroid or Adrenal Disease	Yes	No	Artificial Joint or replacement
Yes	No	Depression, or Anxiety Disorders			

**SURGERIES:** \_\_\_\_\_

**ALLERGIES** to medications, latex, food \_\_\_\_\_

**ARE YOU TAKING?**

Yes	No	Tobacco in any form	Yes	No	Do you use Antacids
Yes	No	Alcohol	Yes	No	Consume grapefruit or grapefruit extract
Yes	No	Recreational Drugs			
Yes	No	Bisphosphonates (for Osteoporosis / Bone) such as: Fosomax, Boniva, Actonel, Zometa, or Aredia?			

Please List All Current Medications (prescription, and over-the-counter) and all Supplements \_\_\_\_\_

**WOMEN ONLY:**

Yes	No	Are you pregnant or nursing	Yes	No	Taking birth control or hormone pills
Yes	No	Have you had a hysterectomy	Yes	No	Taking fertility drugs

**ALL PATIENTS:**

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain \_\_\_\_\_

*To the best of my knowledge, I have answered every question completely and accurately, I will inform my dentist of any changes in my health and/or medication.*

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_