MEDICAL HISTORY

Name ____ Age ________

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

an allergic reaction to:
ibuprofen acetaminophen codeine
penicillin or amoxicillin l local anesthetic latex
other ______________________________

	YES	NO
heart problems, or cardiac stent placed within the last six months		
a history of infective endocarditis		
an artificial heart valve		
a pacemaker or implantable defibrillator		
an orthopedic implant (joint replacement)		
high or low blood pressure		
a stroke (taking blood thinners)		
prolonged bleeding due to a slight cut (INR > 3.5)		
emphysema, shortness of breath, sarcoidosis		
asthma		
sleep apnea or snoring issues		
chronic daytime exhaustion or fatigue		

	YES	NO
high cholesterol		
diabetes (HbA1c =______)		
a stomach or duodenal ulcer		
osteoporosis/osteopenia (ie. taking bisphosphonates)		
an autoimmune disease (i.e. RA/Lupus/Scleroderma)		
epilepsy, convulsions (seizures)		
viral cold sores		
an STI / STD / HPV/ HEP		
radiation/chemo/cancer treatment		
emotional difficulties		
depression		
a touchy / sensitive personality		
an alcohol and/or recreational drug abuse issue		
frequent headaches		
a smoking or tobacco habit - current or past		
FEMALE - a current pregnancy or are you breastfeeding		

Describe any current medical treatment, impending surgery, genetic/developmental delay or other treatment that may possibly affect your dental treatment (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

DENTAL HISTORY

How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist ______________________________ How long have you been a patient? _____ Years

Date of most recent dental exam (MM/YY) _____ /_____ Date of most recent cleaning (MM/YY) _____ /_____

I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
Are you fearful of dental treatment? If so, how fearful on a scale of 1 to 10 [____]		
Have you had an unfavorable dental experience?		
Have you ever had braces, orthodontic treatment, Invisalign or had your bite adjusted?		
Do your gums bleed or are they painful when brushing or flossing?		
Have you ever been treated for gum disease or been told you have lost bone around your teeth?		
Have you ever noticed an unpleasant taste or odor in your mouth?		
Have you had any cavities within the past 3 years?		
Do you have any teeth sensitive to hot, cold, biting, sweets or do you avoid brushing any part of your mouth?		
Do you frequently get food caught between any teeth?		
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)?		
Have your teeth changed in the last 5 years, become shorter, thinner, worn?		
Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?		
Do you wear or have you ever worn a nightguard, retainer and/or partial denture?		
Have you ever whitened (bleached) your teeth?		
Is there anything about the appearance of your teeth that you would like to change?		

I confirm the above is a true and accurate description of my medical and dental history by checking this box

Parents or caregivers may complete this form on the patients behalf Date (DD/MM/YYYY) ___/___/_____