

Medical & Dental History

Date:

Dr. Mr. Mrs. Ms.

Date of Birth:

Street Address:

City: State:

Zip Code:

Phone (Home/Cell): Work:

Email Address:

General Health Assessment: Excellent Good Fair Poor

Physician’s Name:

Height: Weight:

Are you under current medical treatment? Yes No

 If yes, please explain:

Are you currently taking any medication? Yes No

Please list below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  Medication | Dosage |  Reason |  Medication | Dosage |  Reason |
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Have you ever had **joint replacement surgery** or been told that you need to **premedicate** with an antibiotic before a dental visit? Yes No

Have you ever received medications for osteoporosis? Yes No

Do you have any allergies or adverse reaction to drugs? Yes No

If any others, please list:

Women only, please mark if you are:

 Pregnant Nursing Receiving Hormone Replacement Birth control

Please circle if any history of the following:

Artificial Joints Blood disorder Fainting spells

Acid reflux/Heart burn Caffeine dependency Fibromyalgia

Dementia/Memory Loss Cancer Head injuries

High Cholesterol Cardiac problems Kidney disease

HIV/AIDS Stroke Latex sensitivity

Intestinal disorders Drug dependency Hepatitis A B C

Bacterial Endocarditis Epilepsy Major surgeries

Pacemaker Asthma/COPD Organ transplant

Artificial heart valve Sinus problems Mental health issues Headaches Sleep Apnea Thyroid disorder

(Please circle Y or N for yes, no)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Toothaches | N | Y | Mouth breather | N | Y | Jaw joint pain | N | Y |
| Bleeding gums | N | Y | Snoring | N | Y | Popping/clicking | N | Y |
| Oral sores | N | Y | Sleep apnea | N | Y | Limited opening | N | Y |
| Tobacco/toxins | N | Y | Daytime sleepiness | N | Y | Sore Muscles | N | Y |
| Hypertension | N | Y | Poor sleep quality | N | Y | Nerve pain | N | Y |
| Pro-Inflammatory diet | N | Y | Forward head posture | N | Y | Clenching or teeth grinding | N | Y |
| Chronic pain | N | Y | Nasal congestion | N | Y | Uncomfortable bite | N | Y |
| Diabetes | N | Y | Tongue tie | N | Y | Worn teeth | N | Y |
| Gastric reflux | N | Y | Chronic cough | N | Y | Tongue thrust | N | Y |
| Physical inactivity | N | Y | Deviated septum | N | Y | Crooked teeth | N | Y |

Quality of sleep ranking (1-10):

Any other medical condition not listed above?

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

Previous Dentist:

Most recent dental appointment:

Date of most recent set of dental x-rays:

How often have you routinely seen your dentist:

 Every 3 mos Every 4 mos Every 6 mos Every 12 mos Not routinely

What is your chief dental concern?

**Personal History** (please circle yes or no)

1. Are you nervous about coming to the dentist? Yes No

2. Have you ever experienced an adverse reaction to local anesthetic? Yes No

3. Any history of braces or other orthodontic treatment? Yes No

4. Have you ever had a tooth removed? Yes No

5. Do you have any dental implants? Yes No

6. Do you wear complete or partial dentures? Yes No

7. Do you experience dry mouth? Yes No

8. Are you happy with the appearance of your smile? Yes No

9. Any history of trauma to your jaw and/or jaw joints? Yes No

10. Are your teeth crowding or developing spaces? Yes No

11. Do you experience tension headaches, tired muscles, sore teeth? Yes No

12. Do you wear a night time bite appliance? Yes No

13. Have you had your bite adjusted or balanced? Yes No

14. Do you regularly consume soda, juice, sports drinks, candy, or gum? Yes No

15. Have your teeth become shorter or thinner in the last 5 years? Yes No

16. Are any of your teeth sensitive to hot, cold, biting, or sweets? Yes No

17. Have you ever had a toothache, experienced broken tooth, or chipped/cracked a dental filling? Yes No

18. Do you avoid brushing any part of your mouth do to discomfort? Yes No

19. Have you ever been diagnosed or treated for periodontal (gum) disease?

20. Are your teeth becoming loose? Yes No

21. Are you taking any multivitamin/dietary supplements? Yes No

22. Are you a smoker? Yes No

23. How physically active are you?

 Extremely active Active Not active

24. Are you happy and confident with the appearance of your smile? Yes No

 If not, what are your concerns?

25. Please add anything you feel is important:

By signing here, I consent to dental/surgical procedures agreed upon. I will assume responsibility for fees associated with these procedures. To the best of my knowledge, all information I have provided is correct. I commit to informing you of any changes to my health history at my next appointment. I consent to our use and disclosure of protected health information to carry out treatment, payment, and health care operations. I have received a copy of our Notice of Privacy Practices

Patient signature:

Date:

By signing here, I hereby consent to having photographs of my teeth and face taken and used for teaching purposes.

Patient signature:

Doctor signature: