

Medical Health History

Patient Name _____ Age _____ Date of Birth _____

Physician's Name _____ Date of Last Physical _____ Telephone # _____

Your estimate of overall health: Excellent Good Fair Poor

Please check the box of any condition you have or may have had.

Allergies: None

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Cephalosporins | <input type="checkbox"/> Chlorhexidine (CHX) | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Fluoride | <input type="checkbox"/> Gluten | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Latex/Rubber/Vinyl |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Metals: (Nickel, Gold, Silver _____) | | <input type="checkbox"/> Nuts / Fruit | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Other _____ | | |

Health Issues: None

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Abnormal Bleeding/Hemophilia | <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Anemia/Sickle Cell |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Breathing/Sleep Problems |
| <input type="checkbox"/> Chemo/Radiation | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Diabetes A1C _____ | <input type="checkbox"/> Dizziness/Fainting |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Liver Problems/Hepatitis | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Respiratory Disease (COPD) | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tuberculosis |
| | | | <input type="checkbox"/> Ulcers |

Explanation _____

Cardiovascular Disease *(if checked, please specify)*

- | | | | | |
|---|---|---|---------------------------------------|--|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Stroke | <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Damaged Heart Valve | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> High/ Low Blood Pressure | <input type="checkbox"/> Infective Endocarditis | <input type="checkbox"/> Mitral Valve Replacement | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Other _____ | | | | |

Previous/Recent Surgeries _____ Date(s) _____

Are You: None

- | | |
|---|---|
| <input type="checkbox"/> Presently being treated for any other illness _____ | <input type="checkbox"/> Experiencing frequent headaches _____ |
| <input type="checkbox"/> Aware of a change in your health in the last 24 hours:
<i>(i.e. fever, chills, new cough or diarrhea)</i> _____ | <input type="checkbox"/> A smoker, previously smoked or use smokeless tobacco _____ |
| <input type="checkbox"/> Taking medication for weight management _____ | <input type="checkbox"/> Taking birth control pills _____ |
| <input type="checkbox"/> Often exhausted or fatigued _____ | <input type="checkbox"/> Currently pregnant _____ |
| <input type="checkbox"/> Taking / Taken Bisphosphonates _____ | <input type="checkbox"/> Nursing _____ |
| | <input type="checkbox"/> Diagnosed with a prostate disorder _____ |

Medications: None

List all medications, supplements and vitamins

Please make us aware of changes to your health history.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

Dental History Form

Patient Name _____ Age _____

Referred by _____ Previous Dentist's name _____ How long? _____

Date of most recent dental exam ____ / ____ / ____ I see my Dentist (circle): 3 m, 6 m, 12m, other, not routinely

What is your immediate concern? _____

On a scale of 1-10 (10 greatest), how important is your dental health? 1 2 3 4 5 6 7 8 9 10
On a scale of 1-10 (10 greatest), how would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10
On a scale of 1-10 (10 greatest), how fearful are you of dental treatment? 1 2 3 4 5 6 7 8 9 10

Personal History Yes No

- 1. Have you had an unfavorable dental experience? Yes No
- 2. Have you ever had complications from past dental treatment? Yes No
- 3. Have you ever had trouble getting numb or had any reactions to local anesthesia? Yes No
- 4. Do you have, or have you had any teeth removed or teeth that never developed? Yes No
- 5. Did you ever have orthodontic treatment, braces, or your bite adjusted? Yes No

Gum/Bone History - Periodontal Yes No

- 6. Do your gums bleed or do they hurt during brushing/flossing? Yes No
- 7. Have you ever been told you have gum disease or are losing bone around your teeth? Yes No
- 8. Have you ever noticed an unpleasant taste/smell in your mouth? Yes No
- 9. Does anyone in your family have a history of periodontal/gum disease? Yes No
- 10. Have you experienced gum recession (teeth look longer)? Yes No
- 11. Have you ever had any teeth become loose on their own? Yes No

Tooth Structure History - Cavities Yes No

- 12. Have you had any cavities within the past 3 years? Yes No
- 13. Does the amount of your saliva in your mouth seem to little or do you have trouble eating/swallowing food? Yes No
- 14. Do you feel or notice any holes on the tops of your teeth? Yes No
- 15. Are your teeth sensitive to hot, cold, biting, sweets, etc or do you avoid brushing any area? Yes No
- 16. Do you have grooves or notches on your teeth near the gum line? Yes No
- 17. Have you ever broken, chipped, cracked any teeth or had a toothache? Yes No
- 18. Do you get food caught between your teeth? Yes No

Occlusion History - Bite, Jaw & TMJ Yes No

- 19. Do you have problems with your jaw joint? (pain, popping, cracking, locking, etc.) Yes No
- 20. Do you avoid chewing gum, carrots, nuts, hard or chewy foods? Yes No
- 21. Have your teeth changed in the last 5 years, become shorter, thinner or worn? Yes No
- 22. Are your teeth becoming more crooked, crowded, or overlapped? Yes No
- 23. Are your teeth developing spaces or becoming loose? Yes No
- 24. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? Yes No
- 25. Do you clench your teeth during the day or night or wake with a headache? Yes No
- 26. Do you wear, or have you ever worn, a bite appliance? Yes No

Cosmetic History - Smile Yes No

- 27. Is there anything about your appearance of your teeth that you would like to change? Yes No
- 28. Have you ever whitened/bleached your teeth? Yes No
- 29. Have you felt uncomfortable or self-conscious about the appearance of your teeth? Yes No
- 30. Have you been disappointed with the appearance of previous dental work? Yes No