

Dental History

Patient Name _____ Age _____ Date _____
Reason for seeking care today: _____ Exam _____ Cleaning _____ Specific Problem _____
(Please describe)

Please check all that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Bite or teeth have shifted | <input type="checkbox"/> Cracked chops lips | <input type="checkbox"/> Unable to open mouth wide |
| <input type="checkbox"/> Broken filling or tooth | <input type="checkbox"/> Often bite cheeks | <input type="checkbox"/> Bad taste in mouth | <input type="checkbox"/> Jaw gets tired easily |
| Sensitivity to: | <input type="checkbox"/> Frequent dry mouth | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Hold things between teeth |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Concerned about breath | <input type="checkbox"/> Mouth breathe-Difficulty (Pipe, pencil, nails, pins) | <input type="checkbox"/> Bite fingernails |
| <input type="checkbox"/> Hot | <input type="checkbox"/> Unhappy with previous dental work | <input type="checkbox"/> Dry or strained eyes | <input type="checkbox"/> Unusual habits with teeth |
| <input type="checkbox"/> Sweets | <input type="checkbox"/> Gums bleed | <input type="checkbox"/> Shoulder, neck or headaches | <input type="checkbox"/> Wore braces |
| <input type="checkbox"/> Chewing | <input type="checkbox"/> Gums tender | <input type="checkbox"/> Clench or grind teeth | <input type="checkbox"/> Previous gum treatment |
| <input type="checkbox"/> Food catches | <input type="checkbox"/> Growth, sores | <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Previous bite treatment |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Cold sores, fever blisters | <input type="checkbox"/> Clicking or popping of joint | |
| <input type="checkbox"/> Floss breaks easily or hurts | | | |
- Would you like whiter teeth? _____ Is there anything that bothers you (even just a little) about the appearance of you teeth or smile? _____

Please rate 1-10 how anxious you are about dental treatment (1= totally relaxed) _____
Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____
Why did you leave your previous dentist? _____
Did your parents have difficulties with their teeth or dental treatments? _____

Medical History

Physicians Name: _____ Are your allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other? _____
City _____ Phone _____
Have been hospitalized for any reason? Please describe _____
Do you smoke? How much/day? _____
Pregnant? Due date _____ Are you nursing? _____
Are you taking any medications or drugs (including Nutritional supplements?) Please list: (Continue on back of form if needed) _____
Are you seeing a physician now or planning to see one for any reason? Please explain: _____

Please check all that apply:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Previous injury to head or neck | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive problem, ulcer | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Heart problem | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Snoring, sleep apnea |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney problem | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Easily winded |
| <input type="checkbox"/> Angina, chest pain | <input type="checkbox"/> Liver problem, jaundice | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> No energy |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Cirrhosis, Hepatitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Fainting or dizzy |
| <input type="checkbox"/> Scarlet, Rheumatic fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Radiation, Chemotherapy | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Chewing tobacco |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Respiratory problem | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Drug or alcohol addiction |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Bloody, persistent cough | <input type="checkbox"/> Back problem | <input type="checkbox"/> 2 or more social drink/day |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Asthma/Emphysema | <input type="checkbox"/> Hives, Rash, Herpes | <input type="checkbox"/> Anxiety or nervous disorder |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Anemia | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Sickle cell | <input type="checkbox"/> Contact lenses | | |
- Any other illnesses not checked above: _____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: Yes No

Please rate the following indicators of your daily stress level: 1-10: (1 = low, 10 = high)
____ Overworked, too busy, pressured ____ Feel frustrated ____ Get upset, or "snap" easily ____ Depression, anxiety

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian) _____ Date _____

Dentist Signature _____ Date _____