

MEDICAL HISTORY



Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examinaion _____ Purpose _____

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

DO YOU HAVE or HAVE YOU EVER HAD:

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. hospitalization for illness or injury _____ | <input type="checkbox"/> | <input type="checkbox"/> | 26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic or bad reaction to any of the following: | <input type="checkbox"/> | <input type="checkbox"/> | 27. arthritis or gout _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine _____ | | | 28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin _____ | | | 29. glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin _____ | | | 30. contact lenses _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline _____ | | | 31. head or neck injuries _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> sulfa _____ | | | 32. epilepsy, convulsions (seizures) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic _____ | | | 33. neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride _____ | | | 34. viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> chlorhexidine (CHX) _____ | | | 35. any lumps or swelling in the mouth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> iodine _____ | | | 36. hives, skin rash, hay fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (nickel, gold, silver, _____) | | | 37. STI/STD/HPV _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex _____ | | | 38. hepatitis (type ____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> nuts _____ | | | 39. HIV/AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fruit _____ | | | 40. tumor, abnormal growth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> milk _____ | | | 41. radiation therapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> red dye _____ | | | 42. chemotherapy, immunosuppressive medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | | | 43. difficulties with stress management _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last six months _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. psychiatric treatment, antidepressants, mood stabilizing medications _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 45. concentration problems or ADD/ADHD _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 46. alcohol/recreational drug use _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 7. orthopedic or soft tissue implant (e.g., joint replacement, breast implant) | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| 8. heart murmur, rheumatic or scarlet fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | 47. presently being treated for any other illness _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | 48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 49. taking medication for weight management _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> | 50. taking dietary supplements, vitamins, and/or probiotics _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. prolonged bleeding due to a slight cut (or INR > 3.5) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 51. often exhausted or fatigued _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. pneumonia, emphysema, shortness of breath, sarcoidosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 52. experiencing frequent headaches or chronic pain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. chronic ear infections, tuberculosis, measles, chicken pox _____ | <input type="checkbox"/> | <input type="checkbox"/> | 53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. breathing problems (e.g., asthma, stuffy nose, sinus congestion) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 54. considered a touchy/sensitive person _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) | <input type="checkbox"/> | <input type="checkbox"/> | 55. often unhappy or depressed _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 56. taking birth control pills _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease or jaundice _____ | <input type="checkbox"/> | <input type="checkbox"/> | 57. currently pregnant _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. vertigo (e.g., "the room is spinning") _____ | <input type="checkbox"/> | <input type="checkbox"/> | 58. diagnosed with a prostate disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 21. hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 22. high cholesterol or taking statin drugs _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 23. diabetes (HbA1c = _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 24. stomach or duodenal ulcer _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 25. digestive or eating disorders e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

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

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

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY



Patient Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ___/___/___ Date of most recent x-rays ___/___/___
Date of most recent treatment (other than a cleaning) ___/___/___
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:

PERSONAL HISTORY

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [] _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

GUM AND BONE

- | | YES | NO |
|--|--------------------------|--------------------------|
| 7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is there anyone with a history of periodontal disease in your family? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

TOOTH STRUCTURE

- | | YES | NO |
|--|--------------------------|--------------------------|
| 14. Have you had any cavities within the past 3 years? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have grooves or notches on your teeth near the gum line? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you frequently get food caught between any teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT

- | | YES | NO |
|--|--------------------------|--------------------------|
| 21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are your teeth becoming more crooked, crowded, or overlapped? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are your teeth developing spaces or becoming more loose? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you wear or have you ever worn a bite appliance? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE CHARACTERISTICS

- | | YES | NO |
|--|--------------------------|--------------------------|
| 33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever bleached (whitened) your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you been disappointed with the appearance of previous dental work? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____