

MEDICAL HISTORY



Name _____ Age _____

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

DO YOU HAVE or HAVE YOU EVER HAD:

YES NO

an allergic reaction to:

ibuprofen acetaminophen codeine
penicillin or amoxicillin 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 _____

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) ____ / ____ / ____