Medical and Dental History

Patient’s Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s 🞎Current 🞎Previous Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Dental Cleaning\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s 🞎Current 🞎Previous Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Physical Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please take your time to answer the following medical and dental questions to the best of your knowledge.

1. Please list your chief concerns for treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Describe anything that bothers you about your teeth, smile, or face: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Describe any injuries or blows to your face, jaw, mouth, or teeth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. List all current medications including non-prescriptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List all drug allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. List all surgeries or hospitalizations (include dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark if “yes” to every question appropriate, and thoroughly describe (use space at bottom of page)

Medical

1. High blood pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 30. Drink coffee (cups/day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
2. Chest pains or heart attack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 31. Use tobacco (types/how much) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
3. Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 32. Consume alcoholic beverages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
4. Rheumatic fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 33. Pain, popping, or locking of jaw joints \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
5. Shortness of breath or swollen ankles \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 34. Clench or grind your teeth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
6. Any heart trouble, murmur, or mitral valve prolapse\_\_ 🞎 35. Wake up with sore jaws \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
7. Prosthetic devices (heart valve, hip, knee, etc.) \_\_\_\_\_\_ 🞎 36. Frequent headaches (how many per week) \_\_\_\_\_\_\_\_\_ 🞎
8. Any lung disease (T.B., emphysema, etc.) \_\_\_\_\_\_\_\_\_\_\_ 🞎 37. Dizziness, ringing or pain in ears \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
9. Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 38. Tenderness or stiffness in the jaw, neck or back \_\_\_\_\_\_ 🞎
10. Allergies or hay fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 39. History of TMJ (jaw joint) problems or therapy \_\_\_\_\_\_\_ 🞎
11. Sinus problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
12. Mouth breathing or excessive snoring \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
13. Ulcers or stomach problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Dental
14. Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
15. Hepatitis or liver disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 40. Treated for or told you have gum disease \_\_\_\_\_\_\_\_\_\_\_ 🞎
16. Kidney or bladder disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 41. Treated or consulted for orthodontic therapy \_\_\_\_\_\_\_ 🞎
17. Thyroid trouble \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 42. Had an oral surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
18. Connective tissue disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 43. Dental x-rays taken in the last year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
19. Sexually transmitted disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 44. Excessive fear of dental treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
20. Arthritis or rheumatism \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 45. Brush your teeth (how often) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
21. Cancer (type/date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 46. Floss your teeth (how often) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
22. Serious illness not listed (type/date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 47. Bad breath or unpleasant tastes in your mouth \_\_\_\_\_\_ 🞎
23. Subject to prolonged bleeding or bruising \_\_\_\_\_\_\_\_\_\_\_ 🞎 48. Bleeding gums \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
24. Contact lens user \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 49. Sore teeth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
25. Glaucoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 50. Tooth sensitivity (hot, cold, sweets) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
26. Epilepsy, convulsions or seizures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 51. Fever blisters or mouth ulcers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
27. Psychiatric therapy or emotional problems \_\_\_\_\_\_\_\_\_\_ 🞎 52. Suck your thumb \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
28. Do you have HIV/AIDS or Hepatitis C/B? \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 53. Tongue thrusting habit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎
29. Pregnant or possibly pregnant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 54. Gag easily \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎

 55. Place a high priority on keeping your natural teeth \_\_\_ 🞎

Please expand on the above information (refer to letter or number) or add anything you feel is important: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_