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

☐Acetaminophen ☐Aspirin ☐Cephlasporins ☐Chlorhexidine (CHX) ☐Codeine

☐Erythromycin ☐Fluoride ☐Gluten ☐Ibuprofen ☐Latex/Rubber/Vinyl

☐Local Anesthetic ☐Metals: (Nickel, Gold, Silver _____) ☐Nuts / Fruit ☐Penicillin

☐Sulfa ☐Tetracycline ☐Other _____

Health Issues:

☐Abnormal Bleeding/Hemophilia ☐Acid Reflux/GERD ☐AIDS/HIV ☐Anemia/Sickle Cell

☐Arthritis ☐Asthma ☐Autoimmune Disorder ☐Breathing/Sleep Problems ☐Cancer

☐Chemo/Radiation ☐Cold Sores/Fever Blisters ☐Diabetes A1C _____ ☐Dizziness/Fainting ☐Eating Disorder

☐Epilepsy/Seizures ☐Frequent Headaches ☐Glaucoma ☐High Cholesterol ☐Joint Replacement

☐Kidney Problems ☐Liver Problems/Hepatitis ☐Mental Disorder ☐Neurological Problems ☐Organ Transplant

☐Osteoporosis ☐Respiratory Disease (COPD) ☐Thyroid Problems ☐Tuberculosis ☐Ulcers

Explanation _____

☐Cardiovascular Disease ***(if checked, please specify)***

☐Angina ☐Arteriosclerosis ☐Artificial Heart Valve ☐Stroke ☐Congenital Heart Defect

☐Congestive Heart Failure ☐Coronary Heart Disease ☐Damaged Heart Valve ☐Heart Attack ☐Heart Murmur

☐High or Low Blood Pressure ☐Infective Endocarditis ☐Mitral Valve Replacement ☐Pacemaker ☐Rheumatic Fever

☐Other _____

☐Recent Surgeries _____

Are You:

☐Presently being treated for any other illness _____

☐Aware of a change in your health in the last 24 hours:
(i.e. fever, chills, new cough or diarrhea) _____

☐Taking medication for weight management _____

☐Often exhausted or fatigued _____

☐Taking / Taken Bisphosphonates _____

☐Experiencing frequent headaches _____

☐A smoker, previously smoked or use smokeless tobacco _____

☐Taking birth control pills _____

☐Currently pregnant _____

☐Nursing _____

☐Diagnosed with a prostate disorder _____

Medications:

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?	☐	☐
2. Have you ever had complications from past dental treatment?	☐	☐
3. Have you ever had trouble getting numb or had any reactions to local anesthesia?	☐	☐
4. Do you have, or have you had any teeth removed or teeth that never developed?	☐	☐
5. Did you ever have orthodontic treatment, braces, or your bite adjusted?	☐	☐

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

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

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

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