



Dental History

1. What is the primary reason for your dental visit today? _____

2. Have you had any extensive dental work in the past? If yes, please explain. _____

3. Have you seen a periodontist, oral surgeon, or orthodontist in the past? If so, for what reason? _____

4. Do you currently have any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Sensitivity to hot, cold or sweets |
| <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Frequent headaches or jaw pain |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Night guard to prevent tooth grinding |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Orthodontic retainers |
| <input type="checkbox"/> Tenderness when chewing | <input type="checkbox"/> Other concern _____ |

5. How would you rate your current dental health on a scale of 1-10? (1=Poor, 10=Excellent) _____

6. How would you rate the appearance of your smile on a scale of 1-10? (1=Poor, 10=Excellent) _____

7. What, if anything, would you like to change about your smile?

- | | |
|--|--|
| <input type="checkbox"/> Whiteness | <input type="checkbox"/> Spaces between the teeth |
| <input type="checkbox"/> Alignment or crowding | <input type="checkbox"/> Exposed gum tissue |
| <input type="checkbox"/> Size of the teeth | <input type="checkbox"/> Night guard to prevent tooth grinding |
| <input type="checkbox"/> Shape of the teeth | <input type="checkbox"/> Other concern _____ |



Health History / 1

Name (Please Print)		Home Phone		Business/ Cell	
Address (City, State, Zip)					Marital Status
Occupation	Email	Date of Birth		Sex:	
SocSec #	Emerg Contact/ Relationship		Home Phone		Cell Phone
If you are completing this form for another person:	Your Name			Relationship to Patient	

As is required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only, and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information: Please clearly mark the appropriate box

Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?
<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures, partials, retainers or occlusal guards?
<input type="checkbox"/>	<input type="checkbox"/>	Any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?
<input type="checkbox"/>	<input type="checkbox"/>	Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently experiencing dental pain/discomfort?

If currently experiencing dental discomfort, please explain. _____

What is the reason for your visit today? _____

How do you feel about your smile? _____

Medical Information: Please clearly mark the appropriate box

Y **N**
 Are you currently under the care of a physician?

Physician Name (Please Print)		Address			
Phone	Date of Last Exam	BP	Pulse		

 Are you in good health?
 Has there been any change in your general health within the past year?

If yes, what condition is being treated? _____



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<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have a preferred pharmacy? Please provide the name of the pharmacy, and phone number below.</p> <p>_____</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you wear contact lenses?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you had orthopedic total joint replacement (hip, knee, elbow, finger)?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for Osteoporosis or Paget's disease?</p>	<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you use controlled substances? (drugs?)</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you use tobacco? (smoking, snuff, chew, vaping)</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you use medical marijuana?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you drink alcoholic beverages? If yes: How much in the last 24 hrs? _____ How much in a week? _____</p>
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Heart Disease: Please indicate if you have any of the following diseases or problems.
PLEASE NOTE: Except for the following conditions, antibiotic prophylaxis is no longer recommended for any other form of Congenital Heart Disease (CHD).

<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have an artificial (prosthetic) heart valve?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have previous infective endocarditis?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have damaged valves in a transplanted heart?</p>	<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have Congenital Heart Disease (CHD)?</p> <p><input type="checkbox"/> <input type="checkbox"/> Unrepaired, cyanotic CHD?</p> <p><input type="checkbox"/> <input type="checkbox"/> Repaired (completely) in the last 6 months?</p> <p><input type="checkbox"/> <input type="checkbox"/> Repaired CHD with residual defects?</p>
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Medical History: Please indicate if you have had any of the following diseases or problems.

<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Diabetes Type I or II	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Angina	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> If yes, date:	<input type="checkbox"/> Malnutrition	<input type="checkbox"/> ADHD/ADD
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> AIDS or HIV infection	<input type="checkbox"/> Gastrointestinal disease	<input type="checkbox"/> Bipolar
<input type="checkbox"/> Damaged heart valves	<input type="checkbox"/> Arthritis	<input type="checkbox"/> G.E. Reflux	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Persistent heartburn	<input type="checkbox"/> Autism
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Systemic lupus Erythematosus	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Dementia
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> PTSD
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney problems
<input type="checkbox"/> Congenital heart defects	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Mitral valve prolapsed	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Hepatitis, jaundice or liver disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Persistent swollen glands in neck
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Cancer / Chemotherapy / Radiation Treatment	<input type="checkbox"/> Fainting spells/seizures	<input type="checkbox"/> Severe headaches/migraines
<input type="checkbox"/> Rheumatic heart disease	<input type="checkbox"/> Chest pain upon exertion	<input type="checkbox"/> Sleep Disorders	<input type="checkbox"/> Severe or rapid weight loss
<input type="checkbox"/> Abnormal bleeding	<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Snoring	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Anemia			<input type="checkbox"/> Excessive Urination



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Women Only: Please mark the appropriate box

Y	N		Y	N
<input type="checkbox"/>	<input type="checkbox"/>	Pregnant? (Drugs?) How many weeks: _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Nursing?		Taking birth control pills or hormonal replacement?

Medications: Please list any prescription or over-the-counter medicines including vitamins, natural or herbal preparations and/or dietary supplements.

Medicine / Supplement: _____	How much: _____	How often: _____
Medicine / Supplement: _____	How much: _____	How often: _____
Medicine / Supplement: _____	How much: _____	How often: _____
Medicine / Supplement: _____	How much: _____	How often: _____
Medicine / Supplement: _____	How much: _____	How often: _____
Medicine / Supplement: _____	How much: _____	How often: _____

Allergies: Please indicate if you are allergic to or have you had a reaction to any of the following, and list your specific type of reaction.

<input type="checkbox"/> Local Anesthetics _____	<input type="checkbox"/> Latex (rubber) _____
<input type="checkbox"/> Aspirin _____	<input type="checkbox"/> Iodine _____
<input type="checkbox"/> Penicillin/other antibiotics _____	<input type="checkbox"/> Hay Fever / seasonal _____
<input type="checkbox"/> Barbiturates/sedatives/sleeping pills _____	<input type="checkbox"/> Animals _____
<input type="checkbox"/> Sulfa drugs _____	<input type="checkbox"/> Food _____
<input type="checkbox"/> Codeine/other narcotics _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Metals _____	<input type="checkbox"/> Other _____

Surgical History: Please list any operations or reasons that you've been hospitalized.

Type: _____	Year: _____
Type: _____	Year: _____
Type: _____	Year: _____
Type: _____	Year: _____
Type: _____	Year: _____
Hospitalizations: _____	



Health History / 4

Y N

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, please provide name of the physician or dentist and their phone number: _____

Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above, and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

For completion by the dentist: _____

