Dental/Medical History

Name: _____ **Date of Birth:** _____

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following:

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments
- ☐ Dental Implants

Previous Dentist:

City: _____ State: _____

Telephone Number: _____

Please share the following dates:

- Your last cleaning _____
- Your last oral cancer screening _____
- Your last full mouth x-ray _____

On a scale of 1-10, with 10 being the highest rating:

- How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

- Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

If I could change my smile, I would:

- ☐ Make it brighter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace silver fillings with natural, tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns
- ☐ Have a smile makeover

Does coming to the dentist make your nervous or anxious? (circle one) Yes No

What is the most important thing to you about your future smile and dental health? _____

_____

What is the most important thing to you about your dental visit today? _____

_____

Please check any of the following that apply to you:

- ☐ Acid Reflux
- ☐ AIDS
- ☐ Allergies
- ☐ Allergic to Latex
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fosomax
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Lesions
- ☐ Hearth Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Jaw Joint Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Phen Fen
- ☐ Pregnant Currently
- ☐ Radiation
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Smoking
- ☐ Stomache Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Diseases

Other Medical Conditions: _____

Drug Allergies: _____

Current Medication: _____

Family Physician: _____ **Telephone Number:** _____

Address: _____ **Date of Last Exam:** _____

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

Signature of Patient or Guardian: _____ **Date:** _____

SUBMIT