MEDICAL AND DENTAL INFORMATION HISTORY FORM

Patient Name:		Age:
Name of guardian (if required):		
Address:		
Phone Number:	Work Phone:	Ext:
Mobile Phone:	Date of Birth: (MM/DD/YYYY)	
Are your family members patients at this clinic?		☐ Yes ☐ No
Names:		

DENTAL HISTORY

PERSONAL HISTORY	
Does the prospect of dental treatment make you apprehensive?	☐ Yes ☐ No
Have you had a negative dental experience?	☐ Yes ☐ No
Have you ever had complications from previous dental treatments?	☐ Yes ☐ No
When using local anesthetic, do have difficulty getting numb or have you had an adverse reaction?	☐ Yes ☐ No
Did you previously have braces, orthodontic treatment, or have your bite adjusted?	☐ Yes ☐ No
Have any of your teeth been removed?	☐ Yes ☐ No
When was your last dental cleaning/oral hygiene appointment?	☐ Yes ☐ No
When was your last dental visit?	
When was your last set of x-rays taken?	
Have you been advised to take antibiotics before a dental appointment?	☐ Yes ☐ No
TEETH/MOUTH HISTORY	
Do you floss every day?	☐ Yes ☐ No
How many times a day do you brush?	
Is there anything about your teeth or smile that you would like to change?	☐ Yes ☐ No
Have you ever whitened your teeth?	☐ Yes ☐ No
Do you find that you are self conscious about your teeth?	☐ Yes ☐ No
Have you had any cavities within the past 3 years?	☐ Yes ☐ No
Do you have a dry mouth?	☐ Yes ☐ No
Are any of your teeth sensitive to hot, cold, biting, or sweets?	☐ Yes ☐ No
Have you ever had a toothache, cracked filling, broken, chipped, or cracked tooth?	☐ Yes ☐ No
Are there any parts of your mouth you avoid brushing?	☐ Yes ☐ No
Do you have any growths or sore spots in your mouth?	☐ Yes ☐ No

BITE AND JAW	
Do you have any issues chewing gum?	☐ Yes ☐ No
Does chewing bagels or other hard foods cause you any problems?	☐ Yes ☐ No
Have your teeth changed in the last 5 years? Have they become shorter, thinner, or worn?	☐ Yes ☐ No
Do you feel that your teeth are crowding or developing spaces?	☐ Yes ☐ No
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	☐ Yes ☐ No
When you go to sleep at night, do you wake up with an awareness of your teeth?	☐ Yes ☐ No
Do you have any problems with your jaw joint? (Pain, sounds, limited opening, locking, popping.)	☐ Yes ☐ No
Do you get tension headaches or do you have sore teeth?	☐ Yes ☐ No
Do you use or have you ever used a bite appliance?	☐ Yes ☐ No
GUM HISTORY	
Have you been diagnosed with or treated for periodontal disease?	☐ Yes ☐ No
Have you experienced gum recession?	☐ Yes ☐ No
Is there a history of periodontal disease in your family?	☐ Yes ☐ No
Do your gums bleed when brushing, flossing, or eating?	☐ Yes ☐ No
Are your teeth becoming loose?	☐ Yes ☐ No
Have you noticed an unpleasant taste or odor in your mouth?	☐ Yes ☐ No
Do you experience a burning sensation in your mouth?	☐ Yes ☐ No
Do your gums swell and cause you pain?	☐ Yes ☐ No
Have you been diagnosed with or treated for periodontal disease?	☐ Yes ☐ No

MEDICAL HISTORY

PERSONAL HISTORY	
Have you been hospitalized in the past two years?	☐ Yes ☐ No
When was your last visit to a Physician?	☐ Yes ☐ No
Last complete physical examination?	☐ Yes ☐ No
Are you taking any prescription medications?	☐ Yes ☐ No
Are you currently being treated for any other illness?	☐ Yes ☐ No
Physician Name:	
Phone Number:	
Have you ever reacted adversely to any medications or injections?	☐ Yes ☐ No
Do you use or have you used, tobacco products?	☐ Yes ☐ No

CHECK 'YES' IF YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING:			
Allergic reaction to:			
aspirin, ibuprofen, acetaminophen	☐ Yes	erythromycin	☐ Yes
codeine	☐ Yes	latex	☐ Yes

penicillin	☐ Yes	tetracycline	☐ Yes
local anesthetic	☐ Yes	luoride	☐ Yes
metals (gold, stainless steel)	☐ Yes	any other medication:	
heart problems, or cardiac stent within the last 6 months	☐ Yes	history of infective endocarditis	☐ Yes
artifical heart valve	☐ Yes	pacemaker or implantable defibrilator	☐ Yes
scarlet fever	☐ Yes	crohn's disease	☐ Yes
high blood pressure	☐ Yes	low blood pressure	☐ Yes
a stroke (taking blood thinners)	☐ Yes	anemia or other blood disorder	☐ Yes
prolonged or excessive bleeding from a cut or injury	☐ Yes	emphysema or sarcoidosis	☐ Yes
tuberculosis	☐ Yes	asthma	☐ Yes
bronchitis	☐ Yes	breathing or sleep/snoring problems	☐ Yes
kidney disease	☐ Yes	liver disease	☐ Yes
jaundice	☐ Yes	lupus	☐ Yes
thyroid or parathyroid disease, or calcium deficiency	☐ Yes	hormone deficiency	☐ Yes
high cholesterol or statin drugs	☐ Yes	diabetes	☐ Yes
osteoporosis/osteopenia	☐ Yes	cancer	☐ Yes
stomach or duodenal ulcer	☐ Yes	digestive disorders	☐ Yes
arthritis	☐ Yes	glaucoma	☐ Yes
hypoglycemia	☐ Yes	contact lenses	☐ Yes
head or neck injuries	☐ Yes	hypertension	☐ Yes
epilepsy, convulsions (seizures)	☐ Yes	neurologic problems (ADD)	☐ Yes
viral infections and cold sores	☐ Yes	any lumps or swelling in the mouth	☐ Yes
hives, skin rash, hay fever	☐ Yes	venereal disease	☐ Yes
hepatitis (type____)	☐ Yes	HIV / AIDS	☐ Yes
tumor, abnormal growth	☐ Yes	radiation therapy	☐ Yes
chemotherapy	☐ Yes	emotional problems	☐ Yes
psychiatric treatment	☐ Yes	antidepressant medication	☐ Yes
alcohol / drug dependency	☐ Yes		

WOMEN

Are you currently taking birth control medication?	☐ Yes ☐ No
Are you pregnant?	☐ Yes ☐ No

CHILDREN

Has your child recently had any of the following:	
Measles	☐ Yes ☐ No
Mumps	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No
Strep Throat	☐ Yes ☐ No
Tonsilitis	☐ Yes ☐ No