

# 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Names:		

## DENTAL HISTORY

### PERSONAL HISTORY

Does the prospect of dental treatment make you apprehensive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a negative dental experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had complications from previous dental treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
When using local anesthetic, do you have difficulty getting numb or have you had an adverse reaction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you previously have braces, orthodontic treatment, or have your bite adjusted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any of your teeth been removed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
When was your last dental cleaning/oral hygiene appointment?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### TEETH/MOUTH HISTORY

Do you floss every day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many times a day do you brush?	
Is there anything about your teeth or smile that you would like to change?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever whitened your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you find that you are self-conscious about your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any cavities within the past 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a dry mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any of your teeth sensitive to hot, cold, biting, or sweets?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a toothache, cracked filling, broken, chipped, or cracked tooth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any parts of your mouth you avoid brushing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any growths or sore spots in your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>BITE AND JAW</b>	
Do you have any issues chewing gum?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does chewing bagels or other hard foods cause you any problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have your teeth changed in the last 5 years? Have they become shorter, thinner, or worn?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel that your teeth are crowding or developing spaces?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	<input type="checkbox"/> Yes <input type="checkbox"/> No
When you go to sleep at night, do you wake up with an awareness of your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems with your jaw joint? (Pain, sounds, limited opening, locking, popping.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you get tension headaches or do you have sore teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use or have you ever used a bite appliance?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>GUM HISTORY</b>	
Have you been diagnosed with or treated for periodontal disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you experienced gum recession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a history of periodontal disease in your family?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums bleed when brushing, flossing, or eating?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are your teeth becoming loose?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed an unpleasant taste or odor in your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience a burning sensation in your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums swell and cause you pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with or treated for periodontal disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## MEDICAL HISTORY

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

<b>CHECK 'YES' IF YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING:</b>			
Allergic reaction to:			
aspirin, ibuprofen, acetaminophen	<input type="checkbox"/> Yes	erythromycin	<input type="checkbox"/> Yes
codeine	<input type="checkbox"/> Yes	latex	<input type="checkbox"/> Yes

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

### WOMEN

Are you currently taking birth control medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### CHILDREN

Has your child recently had any of the following:

Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No
Strep Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No