

# DENTAL HISTORY

**Please check any of the following problems that apply to you.**

- Sensitivity (hot, cold, sweet)   
Where? UR LR UL LL
- 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

**Do you have or have you had any of the following?**

- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments

**Please share the following dates:**

- Your last cleaning \_\_\_\_\_ / \_\_\_\_\_
- Your last oral cancer screening \_\_\_\_\_ / \_\_\_\_\_
- Your last complete X-Rays \_\_\_\_\_ / \_\_\_\_\_

**Name of Previous Dentist** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

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

**If you could whiten your teeth for a cost anyone could afford, would you do it?**

**Do you smoke or use chewing tobacco?**   
How much? \_\_\_\_\_ For how long? \_\_\_\_\_

**If I could change my smile, I would:**

- Make them whiter
- Make them straighter
- Close spaces
- Replace black metal fillings with tooth colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

**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

-Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

**Why did you leave your previous dentist?** \_\_\_\_\_

**What is the most important thing to you about your dental visit today?** \_\_\_\_\_

# MEDICAL HISTORY

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

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> AIDS                   | <input type="checkbox"/> Drug Addiction             | <input type="checkbox"/> HIV Positive           | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Allergies (Seasonal)   | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Rheumatism        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Excessive Bleeding         | <input type="checkbox"/> Jaw Joint Pain         | <input type="checkbox"/> Scarlet Fever     |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Stomach Problems  |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Heart Conditions           | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart Lesions (Congenital) | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Heart Surgery              | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Hepatitis A                | <input type="checkbox"/> Phen Fen (1 month +)   | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Hepatitis B                | <input type="checkbox"/> Pregnant Currently     | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hepatitis C                | <input type="checkbox"/> Radiation (head/neck)  |  |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Respiratory Problems   |  |

**Do you have any of the following drug allergies?**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Aspirin          | <input type="checkbox"/> Codeine      |
| <input type="checkbox"/> Darvon           | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Nitrous Oxide    | <input type="checkbox"/> Valium       |
| <input type="checkbox"/> Percodan         | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Sulfa        |
| <input type="checkbox"/> Tetracycline     | <input type="checkbox"/> Other        |

**Patient Signature or Guardian** \_\_\_\_\_

**Are you under a physician's care? What for?** \_\_\_\_\_

**Are you taking any medications? What?** \_\_\_\_\_

**Family Physician** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**Date** \_\_\_\_\_ **Dentist Signature** \_\_\_\_\_