DENTAL HISTORY

Patient Name:_____

Please check any of the following that apply to you.	Yes	No
-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	☐	☐

	Yes	No
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 my teeth brighter	☐	☐
-Make my teeth straighter	☐	☐
-Close spaces	☐	☐
-Replace black metal fillings with natural, tooth-colored fillings	☐	☐
-Repair my chipped teeth	☐	☐
-Replace any missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐

Please share the following dates:

Your last cleaning ____/____
Your last oral cancer screening ____/____
Your last complete X-Rays ____/_____

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

-Where would you rate your current dental health?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
- How important is your dental health to you?
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 ☐

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

_____

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

_____

MEDICAL HISTORY

Please check any of the following that apply to you:

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

Do you have any of the following drug allergies?

☐☐Aspirin ☐☐ Codeine
☐☐Darvon ☐☐ Erythromycin
☐☐Nitrous Oxide ☐☐ Valium
☐☐Percodan ☐☐ Penicillin
☐☐Local Anesthetic ☐☐Other, please list _____

Are you under a physician's care? Why?

_____

What medications do you take?

_____

_____

_____

Is there any other medical or dental information we should know? _____

_____

***Patient Signature** **Date** **Dentist Signature** **Date**
(Parent of Child)