DENTAL HISTORY

(WE NEED THE FOLLOWING **CONFIDENTIAL** HEALTH INFORMATION ABOUT THE PATIENT)

	Yes	No
1. HAVE YOU COME TO THIS OFFICE FOR PAIN RELIEF?	☐	☐

IF YES, HOW LONG HAS IT HURT? _____

WHERE IS THE PAIN? _____

HOW DOES IT HURT? WITH:

☐HOT ☐COLD ☐SWEETS ☐CONSTANTLY

2. HOW LONG SINCE YOU'VE BEEN TO A DENTIST? _____

3. HOW OFTEN DID YOU VISIT A DENTIST BEFORE THEN?

☐REGULAR, EVERY 6 MONTHS ☐IRREGULARY

☐REGULAR, EVERY YEAR ☐ALMOST NEVER

4. WHEN WAS YOUR LAST SET OF FULL MOUTH X-RAYS? _____

5. HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE (GUM DISEASE)?	☐	☐

6. HOW OFTEN DO YOU BRUSH YOUR TEETH? _____

7. PLEASE CHECK ANY ITEMS BELOW THAT YOU USE OFTEN IN ORAL CARE:

☐HAND TOOTH BRUSH ☐ELECTRIC TOOTH BRUSH

☐DENTAL FLOSS ☐GUM STIMULATORS

☐RUBBER TIPS ☐WATER SPRAY (WATER-PIC)

8. DO YOUR GUMS BLEED WHEN YOU BRUSH?	☐	☐
9. HAVE YOU EVER HAD YOUR TEETH STRAIGHTENED?	☐	☐
10. HAVE YOU EVER HAD ANY INJURY TO YOUR FACE OR JAWS?	☐	☐

IF YES, EXPLAIN _____

11. HAVE YOU EVER HAD A CLICKING OR POPPING NEAR YOUR EAR WHEN YOU CHEW?	☐	☐
12. DO YOU GRIND YOUR TEETH?	☐	☐
13. DO YOU HAVE SORES, BLISTERS OR SWELLING ON YOUR GUMS, LIPS OR CHEEKS?	☐	☐

IF YES, HOW LONG HAVE THEY BEEN PRESENT? _____

WHERE ARE THEY? _____

14. HAVE YOU EVER LOST ANY PERMANENT TEETH?	☐	☐

IF YES, FOR WHAT REASON?

☐DECAY ☐GUM DISEASE ☐INJURY ☐OTHER

15. HAVE YOU EVER HAD ANY COMPLICATIONS FROM AN EXTRACTION?	☐	☐

IF YES, PLEASE EXPLAIN _____

IF YOU CAME TO THIS OFFICE FOR A NEW DENTURE, COMPLETE THE FOLLOWING PORTION:

16. WHEN WERE YOUR NATURAL TEETH REMOVED? _____

17. HOW MANY SETS OF DENTURES HAVE YOU HAD? _____

18. WHEN WERE YOUR PRESENT DENTURES CONSTRUCTED? _____

19. DO YOU LIKE THE APPEARANCE OF YOUR PRESENT SET OF DENTURES?	☐	☐
20. HAS YOUR PRESENT SET OF DENTURES EVER BEEN RELINED OR REBASED?	☐	☐

IF PATIENT IS A CHILD, PLEASE ANSWER THE FOLLOWING QUESTIONS:

21. PLEASE CHECK ANY OF THE FOLLOWING HABITS THE CHILD HAS:

☐THUMBSUCKING ☐NAILBITING

☐MOUTHBREATHING ☐UNUSUAL SPEECH PATTERNS

22. DO YOU RECEIVE FLUORIDE IN ☐VITAMINS ☐TABLETS ☐WATER	☐	☐

MEDICAL HISTORY

	Yes	No
1. HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH? ☐ POOR ☐ FAIR ☐ GOOD ☐ EXCELLENT		
2. ARE YOU NOW BEING TREATED OR HAVE YOU BEEN TREATED IN THE LAST YEAR BY A PHYSICIAN?	☐	☐

IF YES, FOR WHAT CONDITION? _____

3. DATE OF LAST MEDICAL EXAMINATION _____

4. NAME OF YOUR PHYSICIAN _____

5. HAVE YOU BEEN TAKING ANY MEDICINES OR DRUGS IN THE PAST YEAR?	☐	☐

IF YES, PLEASE LIST: _____

6. HAVE YOU BECOME SICK FROM, SHOWN ALLERGY TO, OR BEEN TOLD NOT TO TAKE: ☐ ANTIBIOTICS (PENICILLIN) ☐ CODEINE OR NARCOTICS ☐ ANESTHESIA (NOVOCAINE, ETC.) ☐ OTHER _____	☐	☐
7. DO YOU WEAR A CARDIAC PACEMAKER?	☐	☐
8. WOMEN - ARE YOU PREGNANT AT THIS TIME?	☐	☐

9. HAVE YOU EVER HAD ANY OF THE FOLLOWING: (PLEASE CHECK)

☐ ANEMIA	☐ HEART MURMUR	☐ RHEUMATIC FEVER	☐ TIGHTNESS IN CHEST	☐ DIFFICULTY SWALLOWING	☐ CHEMOTHERAPY (CANCER, LEUKEMIA)
☐ STROKE	☐ TUBERCULOSIS	☐ MENTAL DISORDERS	☐ FREQUENT HEADACHES	☐ PSYCHIATRIC TREATMENT	☐ HISTORY OF DIABETES IN YOUR FAMILY
☐ DIABETES	☐ BLOOD DISEASE	☐ PERSISTENT COUGH	☐ ASTHMA OR HAY FEVER	☐ X-RAY OR COBALT TREATMENT	☐ ARTHRITIS OR PAINFUL SWOLLEN JOINTS
☐ EPILEPSY	☐ HEART DISEASE	☐ TUMORS OR ULCERS	☐ HIGH BLOOD PRESSURE	☐ CONTINUAL THIRSTY FEELING	☐ SHORTNESS OF BREATH ON MILD EXERTION
☐ EMPHYSEMA	☐ HEART SURGERY	☐ JOINT REPLACEMENT	☐ RESPIRATORY DISEASE	☐ JAUNDICE OR LIVER DISEASE	☐ KIDNEY OR BLADDER DISEASE OR INFECTION
☐ HEPATITIS	☐ SINUS TROUBLE	☐ ALLERGIES OR HIVES	☐ ARTIFICIAL PROSTHESIS	☐ SWELLING IN ANKLES OR FEET	☐ ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)
☐ COLD SORES	☐ DRUG ADDICTION	☐ DRY BURNING MOUTH	☐ AIDS RELATED COMPLEX	☐ FAINTING SPELLS, CONVULSIONS	☐ VENEREAL DISEASE (HERPES, SYPHILIS, GONORRHEA)

10. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM YOU THINK I SHOULD KNOW ABOUT: IF SO PLEASE EXPLAIN _____

I CONFIRM AS TRUE THE ABOVE HEALTH INFORMATION: SIGNATURE _____ DATE _____

CHANGES IN HEALTH _____ DATE _____