

DENTAL HISTORY

| | | |
|---|-----|----|
| Do you have a specific dental problem? Describe: | Yes | No |
| Do you have regular dental care? Last visit? | Yes | No |
| Do you think you have decay, gum disease, or jaw problems? | Yes | No |
| Do you floss? How often? | Yes | No |
| Do your gums ever bleed? | Yes | No |
| Are you interested in improving your smile? | Yes | No |
| Would you like to have whiter teeth? | Yes | No |
| Does food catch between your teeth? Do you have any loose teeth? | Yes | No |
| Do you ever have clicking, popping or discomfort in your jaw joint? Do you clench or grind? | Yes | No |
| Have you ever had a bad experience with a dentist? | Yes | No |
| Do you smoke or chew tobacco? | Yes | No |
| Name of previous dentist and location (optional) | | |
| Last date of xrays: Bitewings: _____ Panorex: _____ Full series: _____ | | |

Symptoms

Check all that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Postural Problems |
| <input type="checkbox"/> TMJ Pain | <input type="checkbox"/> Clenching / Bruxing | <input type="checkbox"/> Tingling in Fingers |
| <input type="checkbox"/> TMJ Noise | <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Hot / Cold Sensitivity |
| <input type="checkbox"/> Limited Opening | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Nervous / Anxious |
| <input type="checkbox"/> Ear Congestion | <input type="checkbox"/> Tender Sensitive Teeth | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty Chewing | <input type="checkbox"/> Trigeminal Neuralgia |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Difficulty Swallowing | | |

MEDICAL HISTORY

Circle all that apply

| | | | |
|-----------------------------------|----------------------|----------------------------------|-----------------|
| Heart Murmur | Lung Disease | Blood Disease | Thyroid Disease |
| Angina/Chest pain | Allergies | Blood pressure problem | Kidney Disease |
| Heart Attack/failure | Sinus problems | Bleed easily | Liver Disease |
| Congenital Heart Disorder | Asthma | Hepatitis A,B,orC | Diabetes |
| Mirtal Valve Prolapse | Epilepsy or Seizures | HIV+ / Aids | Glaucoma |
| Artificial Heart Valve | Rheumatic Fever | Venereal Disease | Snoring |
| Heart Pace maker | Cold sores | Cancer/Chemo/Radiation | |
| Artificial Joints (hip,knee, etc) | Fever blisters | Psychiatric / Psychological Care | |

Are you under a physician's care? Why? _____

Name _____ Phone _____

Are you taking any medications? What? _____

Are you allergic to any medications? What? _____

Penicillin Codeine Sulpha Latex Metals Acrylic

Are you pregnant or trying? Contraceptives? _____

Have you had a serious accident or hospitalization? _____

Normal blood pressure (if known)? _____

MEDICAL HISTORY REVIEW:

Dentist Signature: _____ Date: _____

DENTAL HISTORY REVIEW