

Patient Name: _____ Date of Birth: _____

I. DENTAL HISTORY

Why have you come to see us today? (pain, checkup, etc.) _____

Former Dentist/Dental Office: _____ Date of most recent dental exam: _____

Reasons for changing dentists? _____ Date of most recent dental treatment: _____

Please circle the appropriate answer (leave blank if you do not understand question):

- | | |
|---|--|
| 1. Yes No I currently have pain with my teeth, gums, or mouth. | 11. Yes No My jaw clicks, pops, and/or locks. |
| 2. Yes No I have problems eating. | 12. Yes No My teeth are sensitive to hot or cold. |
| 3. Yes No I avoid brushing part of my mouth due to pain. | 13. Yes No My teeth are sensitive to sweets. |
| 4. Yes No I have loose or broken teeth or fillings. | 14. Yes No I have sensitivity, discomfort, or pain when biting or chewing. |
| 5. Yes No I have sores or growths in my mouth. | 15. Yes No I clench or grind my teeth during the day or while sleeping. |
| 6. Yes No My gums bleed while brushing or flossing. | 16. Yes No I have dry mouth. |
| 7. Yes No I have had a periodontal treatment, or a deep cleaning. | 17. Yes No I like my smile. |
| 8. Yes No I have had facial or jaw injury or surgery. | 18. Yes No I want to change or improve my smile. |
| 9. Yes No I have had braces or orthodontic treatment in the past. | 19. Yes No I want to straighten my teeth. |
| 10. Yes No I have trouble getting/staying numb with dental treatment. | 20. Yes No I want to whiten my teeth. |

21. Have you ever had other problems with or complications after dental treatment? Yes No If so, please explain: _____

22. How often do you floss? _____ 23. How often do you brush? _____

II. HEALTH HISTORY

Primary Care Physician's Name: _____ Date of most recent visit: _____

INDICATE IF YOU HAVE OR HAVE HAD THE FOLLOWING CONDITIONS, OR IF YOU ARE TAKING OR HAVE TAKEN THESE DRUGS:

- | | | |
|--|--|---|
| 24. Yes No High blood pressure | 38. Yes No Asthma | 52. Yes No Dementia / Alzheimer's |
| 25. Yes No Heart attack | 39. Yes No COPD, Emphysema, Bronchitis | 53. Yes No Anxiety, depression, other psychiatric care |
| 26. Yes No Heart murmurs or AFIB | 40. Yes No Tuberculosis | 54. Yes No Sinus problems |
| 27. Yes No Heart disease | 41. Yes No Other respiratory problems | 55. Yes No Stomach problems, ulcers |
| 28. Yes No Heart defects | 42. Yes No Cancer | 56. Yes No Epilepsy or seizures |
| 29. Yes No Prosthetic heart valve | Type _____ Date _____ | 57. Yes No Fainting or dizziness |
| 30. Yes No Pacemaker | 43. Yes No Chemotherapy | 58. Yes No Autoimmune disorders (Sjogren's, Hashimoto's, etc) |
| 31. Yes No Other heart problems | 44. Yes No Kidney Disease | 59. Yes No Glaucoma or other eye diseases |
| 32. Yes No Anemia | 45. Yes No Liver Disease | 60. Yes No Skin diseases |
| 33. Yes No Hemophilia, other bleeding issues | 46. Yes No Hepatitis Type _____ | 61. Yes No Herpes / Cold Sores |
| 34. Yes No Blood transfusions | 47. Yes No Thyroid, adrenal problems | 62. Yes No HIV/AIDS |
| 35. Yes No High Cholesterol | 48. Yes No Organ transplant | 63. Yes No Other STDs (HPV, syphilis, gonorrhea, etc) |
| 36. Yes No Stroke, TIA | 49. Yes No Arthritis | 64. Yes No Tobacco in any form, vaping |
| 37. Yes No Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II | 50. Yes No Artificial joint | 65. Yes No Alcohol |
| Most Recent HbA1c _____ Date _____ | 51. Yes No Osteoporosis & related medication | 66. Yes No Recreational drugs |

67. Yes No Current prescription and/or over-the-counter medications, vitamins and supplements, natural remedies? Please list: _____

68. Yes No Allergy to: Latex Penicillin Azithromycin Clindamycin Other medications: _____

69. Yes No Other allergies: _____ 70. Yes No Direction from physician to avoid Ibuprofen or Tylenol

71. Yes No Surgeries Please list what surgery and year they were performed _____

72. Yes No Other medical conditions, problems, or medical history NOT already listed on this form? If so, please describe: _____

WOMEN ONLY:

73. Yes No Pregnant, Possibly Pregnant, Trying to Become Pregnant, Nursing Due Date: _____ 74. Yes No Taking birth control

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ Doctor's signature: _____ Date: _____

RECALL REVIEW:

- | | | |
|-------------------------------|---------------------------|-------------|
| 1. Patient's signature: _____ | Doctor's signature: _____ | Date: _____ |
| 2. Patient's signature: _____ | Doctor's signature: _____ | Date: _____ |
| 3. Patient's signature: _____ | Doctor's signature: _____ | Date: _____ |