MEDICAL HISTORY

Name _____ Age _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

an allergic reaction to:
☐ ibuprofen ☐ acetaminophen ☐ codeine
☐ penicillin or amoxicillin ☐ local anesthetic ☐ latex
☐ other _____

	YES	NO
heart problems, or cardiac stent placed within the last six months	☐	☐
a history of infective endocarditis _____	☐	☐
an artificial heart valve _____	☐	☐
a pacemaker or implantable defibrillator _____	☐	☐
an orthopedic implant (joint replacement) _____	☐	☐
high or low blood pressure _____	☐	☐
a stroke (taking blood thinners) _____	☐	☐
prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
emphysema, shortness of breath, sarcoidosis _____	☐	☐
asthma _____	☐	☐
sleep apnea or snoring issues _____	☐	☐
chronic daytime exhaustion or fatigue _____	☐	☐

	YES	NO
high cholesterol _____	☐	☐
diabetes (HbA1c = _____) _____	☐	☐
a stomach or duodenal ulcer _____	☐	☐
osteoporosis/osteopenia (ie. taking bisphosphonates) _____	☐	☐
an autoimmune disease (i.e. RA/Lupus/Scleroderma) _____	☐	☐
epilepsy, convulsions (seizures) _____	☐	☐
viral cold sores _____	☐	☐
an STI / STD / HPV/ HEP _____	☐	☐
radiation/chemo/cancer treatment _____	☐	☐
emotional difficulties _____	☐	☐
depression _____	☐	☐
a touchy / sensitive personality _____	☐	☐
an alcohol and/or recreational drug abuse issue _____	☐	☐
frequent headaches _____	☐	☐
a smoking or tobacco habit - current or past _____	☐	☐
FEMALE - a current pregnancy or are you breastfeeding _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/developmental delay or other treatment that may possibly affect your dental treatment (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

DENTAL HISTORY

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____ How long have you been a patient? _____ Years

Date of most recent dental exam (MM/YY) _____ /_____ Date of most recent cleaning (MM/YY) _____ /_____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
Are you fearful of dental treatment? If so, how fearful on a scale of 1 to 10 [____] _____	☐	☐
Have you had an unfavorable dental experience? _____	☐	☐
Have you ever had braces, orthodontic treatment, Invisalign or had your bite adjusted? _____	☐	☐
Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
Have you had any cavities within the past 3 years? _____	☐	☐
Do you have any teeth sensitive to hot, cold, biting, sweets or do you avoid brushing any part of your mouth? _____	☐	☐
Do you frequently get food caught between any teeth? _____	☐	☐
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? _____	☐	☐
Have your teeth changed in the last 5 years, become shorter, thinner, worn? _____	☐	☐
Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____	☐	☐
Do you wear or have you ever worn a nightguard, retainer and/or partial denture? _____	☐	☐
Have you ever whitened (bleached) your teeth? _____	☐	☐
Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐

I confirm the above is a true and accurate description of my medical and dental history by checking this box ☐

Parents or caregivers may complete this form on the patients behalf Date (DD/MM/YYYY) ___/___/_____