IMPORTANT

Please Read

In order to successfully submit these forms online it will require you to use the Adobe Acrobat Reader plugin for your web browser. If you do not have that you can click the link below and install it.

If you attempt to fill out these forms and submit them online using Adobe Acrobat Reader itself, or another similar utility, this will fail.

However, if you wish you can print out the forms using Adobe Acrobat Reader, or another similar utility, fill them out and bring them to your appointment.

Thank you for your cooperation.

MEDICAL HISTORY

Patient Name Nickname Age

Name of Physician/and their specialty

Most recent physical examination Purpose

What is your estimate of your general health ◯ Excellent ◯ Good ◯ Fair ◯ Poor

DO YOU HAVE or HAVE YOU EVER HAD	YES	NO
1. hospitalization for illness or injury _____	◯	◯
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ codeine		
☐ local anesthetic		
☐ fluoride		
☐ metals (gold, stainless steel)		
☐ latex		
☐ any other medications		
3. heart problems _____	◯	◯
4. heart murmur _____	◯	◯
5. rheumatic fever _____	◯	◯
6. scarlet fever _____	◯	◯
7. high blood pressure _____	◯	◯
8. low blood pressure _____	◯	◯
9. a stroke _____	◯	◯
10. artificial prosthesis (i.e. heart valve or joints _____	◯	◯
11. anemia or other blood disorder _____	◯	◯
12. prolonged bleeding due to a slight cut _____	◯	◯
13. emphysema _____	◯	◯
14. tuberculosis _____	◯	◯
15. asthma _____	◯	◯
16. breathing or sleep problems (i.e. snoring, sinus) ____	◯	◯
17. kidney disease _____	◯	◯
18. liver disease _____	◯	◯
19. jaundice _____	◯	◯
20. thyroid or parathyroid disease _____	◯	◯
21. hormone deficiency _____	◯	◯
22. high cholesterol _____	◯	◯
23. diabetes _____	◯	◯
24. stomach or duodenal ulcer _____	◯	◯
25. digestive disorders (i.e. gastric reflux _____	◯	◯
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	◯	◯
27. arthritis _____	◯	◯
28. glaucoma _____	◯	◯
29. contact lenses _____	◯	◯
30. head or neck injuries _____	◯	◯
31. epilepsy, convulsions (seizures) _____	◯	◯
32. neurologic problems _____	◯	◯
33. viral infections and cold sores _____	◯	◯
34. any lumps or swelling in the mouth _____	◯	◯
35. hives, skin rash, hay fever _____	◯	◯
36. venereal disease _____	◯	◯
37. hepatitis (type ___) _____	◯	◯
38. HIV/AIDS _____	◯	◯
39. tumor, abnormal growth _____	◯	◯
40. radiation therapy _____	◯	◯
41. chemotherapy _____	◯	◯
42. emotional problems _____	◯	◯
43. psychiatric treatment _____	◯	◯
44. antidepressant medication _____	◯	◯
45. alcohol/drug dependency _____	◯	◯
ARE YOU:		
46. presently being treated for any other illness _____	◯	◯
47. aware of a change in your general health _____	◯	◯
48. taking medication for weight management (fen-pher)	◯	◯
49. taking dietary supplements _____	◯	◯
50. often exhausted or fatigued _____	◯	◯
51. subect to frequent headaches _____	◯	◯
52. a smoker or smoked previously _____	◯	◯
53. considered a touchy person _____	◯	◯
54. often unhappy or depressed _____	◯	◯
55. FEMALE - taking birth control pills _____	◯	◯
56. FEMALE - pregnant _____	◯	◯
57. MALE - prostate disorders _____	◯	◯

Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment.

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

Drug	Purpose	Drug	Purpose

Ask for additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Referred by How would you rate the condition of your mouth? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Previous Dentist How long have you been a patient? Months/Years

Date of most recent dental exam / / Date of most recent x-rays / /

Date of most recent treatment (other than a cleaning) / /

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**

PERSONAL HISTORY

1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____ ◯ ◯
2. Have you had an unfavorable dental experience? _____ ◯ ◯
3. Have you ever had complications from past dental treatment? _____ ◯ ◯
4. Have you ever had trouble getting numb or reactions to local anethetic? _____ ◯ ◯
5. Did you ever have braces, orthondontic treatment or had your bite adjusted? _____ ◯ ◯
6. Have you had any teeth removed? _____ ◯ ◯

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ◯ ◯
8. Have you ever whitened (bleached) your teeth? _____ ◯ ◯
9. Are you self conscious about your teeth? _____ ◯ ◯
10. Have you been disappointed with the appearance of previous dental work? _____ ◯ ◯

BITE AND JAW JOINT

11. Do you/would you have any problems chewing gum? _____ ◯ ◯
12. Do you/would you have any problems chewing bagels or other hard food? _____ ◯ ◯
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ◯ ◯
14. Are your teeth crowding or developing spaces? _____ ◯ ◯
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____ ◯ ◯
16. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ◯ ◯
17. Do you have problems withy your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ◯ ◯
18. Do you have tension headaches or sore teeth? _____ ◯ ◯
19. Do you wear or have you ever worn a bite appliance? _____ ◯ ◯

TOOTH STRUCTURE

20. Have you had any cavities within the past 3 years? _____ ◯ ◯
21. Do you have a dry mouth? _____ ◯ ◯
22. Are any teeth sensitive to hot, cold, biting or sweets? _____ ◯ ◯
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____ ◯ ◯
24. Do you avoid brushin any part of your mouth? _____ ◯ ◯
25. Do you feel or notice any holes (i.e. pitting) in your teeth? _____ ◯ ◯

GUM AND BONE

26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____ ◯ ◯
27. Have you ever experienced gum recession? _____ ◯ ◯
28. Is there anyone with a history of periodontal disease in your family? _____ ◯ ◯
29. Do your gums bleed when brushing, flossing or eating? _____ ◯ ◯
30. Are your teeth becoming loose? _____ ◯ ◯
31. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ◯ ◯
32. Have you experienced a burning sensation in your mouth? _____ ◯ ◯

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Submit