Patient Dental History

Date of last dental appointment_____ **Reason for today's visit?** _____
How often do you brush your teeth? _____ **How often do you floss?** _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold foods/liquids?	☐	☐
3. Are your teeth sensitive to sweet or sour foods/liquids?	☐	☐
4. Are any particular teeth causing you discomfort?	☐	☐
5. Do you have any sores/lumps in or near your mouth?	☐	☐
6. Have you ever had any head, neck or jaw injuries?	☐	☐
7. Do you clench or grind your teeth?	☐	☐
8. Do you bite your lips or cheeks frequently?	☐	☐
9. Have you ever had any difficult extractions in the past?	☐	☐
10. Have you ever had prolonged bleeding associated with any dental treatment?	☐	☐

How would you rate your smile on a scale of 1-10? (10 being the best) 1 2 3 4 5 6 7 8 9 10

Patient Medical History

Physician _____ **Office Phone** _____ **Date of Last Exam** _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness?	☐	☐
3. Do you take aspirin regularly?	☐	☐
4. Do you use tobacco products?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Do you wear contact lenses?	☐	☐
7. Do you wear a hearing aid?	☐	☐
8. Women only:		
(a) Are you or think you might be pregnant?	☐	☐
(b) Are you nursing?	☐	☐
(c) Are you taking oral contraceptives?	☐	☐
(d) Do you have any problems associated with your menstrual period?	☐	☐
9. Are you allergic or have you reacted adversely to any of the following:		
Local Anesthetics (e.g. Novocain)?	☐	☐
Penicillin or other antibiotics?	☐	☐
Sulfa Drugs?	☐	☐
Barbiturates?	☐	☐
Sedatives?	☐	☐
Iodine?	☐	☐
Aspirin?	☐	☐
Any metals (Nickel, Mercury, etc.)?	☐	☐
Latex?	☐	☐
10. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If so, what medications are you taking? Dosage

_____ _____
_____ _____
_____ _____

☐ Acid Reflex (heartburn)
☐ Artificial joints
☐ Blood Disease
☐ Circulatory Problems
☐ Fainting
☐ Heart Murmur
☐ Jaw Pain
☐ Neck Pain
☐ Pacemaker
☐ Respiratory Problems
☐ Shortness of Breath
☐ STD's (Venereal Diseases)
☐ Thyroid Problems

☐ AIDS or HIV infection
☐ Arthritis
☐ Cancer
☐ Diabetes
☐ Glaucoma
☐ Hepatitis
☐ Joint Replacement
☐ Nervous Disorders
☐ Panic Attacks
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stomach Problems
☐ Tobacco Use

☐ Allergies
☐ Asthma
☐ Chemical Dependency
☐ Dizziness
☐ Hay Fever
☐ High/low Blood Pressure
☐ Kidney Disease
☐ Pregnancy--Due date_____
☐ Psychiatric Care
☐ Seizures
☐ Sleep Apnea
☐ Stroke
☐ Tuberculosis

☐ Anemia
☐ Back Problems
☐ Eating Disorder
☐ Headaches
☐ Liver Disease
☐ Radiation Treatment
☐ Shoulder Pain
☐ Snoring
☐ Swelling of feet or ankles
☐ Tumors

☐ Anxiety
☐ Bleeding Disorder
☐ Chemotheraphy
☐ Epilepsy
☐ Heart Disease
☐ Angina Pectoris
☐ By-Pass Surgery
☐ Congenital Heart failure/lesion
☐ MI
☐ Valve Replacemt
☐ Ulcers

TMJ/MFP History

☐ Back Pain
☐ Dizziness
☐ Ear Congestion
☐ Ear Pain
☐ Eye Pain
☐ Facial Pain
☐ Fatigue
☐ Headaches
☐ Jaw Clicking
☐ Jaw Joint Noises
☐ Jaw Locking
☐ Limited Mouth Opening
☐ Muscle Soreness
☐ Muscle Twitching
☐ Pain when chewing
☐ Ringing in the ears
☐ Shoulder Pain
☐ Sinus Congestion
☐ Throat Pain
☐ Tinnitis
☐ Visual Disturbances

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I also agree to allow release of my treatment/x-rays for the purpose of collecting reimbursement from my insurance carrier.

_____ _____
Signature date

Reviewed by **Date** **Comments**

_____/_____/_____
_____/_____/_____