Are you aware of the link between the bacteria in your mouth and your overall health?

Dental History	Yes	No
Are your teeth sensitive to (circle which apply):		
Heat Cold Sweets Pressure		
If yes, please explain:		
Does food catch between your teeth?		
If yes, please state location:		
Do your gums bleed when brushing or flossing?		
Do you feel you have bad breath?		
Have you ever had a "deep cleaning" (below your gums and usually requiring		
local anesthetic)?		
Do you have any problems with your jaw joint (TMJ)?		
Clicking?		
Jaw Pain (Joints, ear side of face)?		
Difficulty chewing?		
Locking open or closed?		
Headaches when awakening?		
Have you ever had an adverse reaction to anesthetics?		
If yes, please describe:		
Do you currently or have you ever used tobacco products?		
If yes, please circle: cigarettes chewing tobacco vaping e-cigarettes smoking marijuana		
When was your last oral cancer screening?		
Do you have any lumps, bumps, or sores in your mouth that have not healed within 10 days?		
If yes, please state location:		
Do you have missing teeth?		
If so, how long have they been missing?		Years
Rate your smile on a scale of 1-10		
What would make your smile a 10?		
Why did you leave your last dentist?		
When was your last dental appointment?		
When was your last dental cleaning?		
Have you ever have orthodontic treatment?		
Rate your anxiety you have about dental treatment 1-10		
Are you interested in learning more about sedation options for dental care?		
What is your chief dental concern?		
What can we do to make your appointment more comfortable?		

Health History	Yes	No	Date Diagnosed
Are you under a physician's care at this time?			
If yes, please explain and list the name and phone number for your MD:			
Have you ever been treated for a bone disorder (ie osteoporosis)?			
Have you ever been treated for any kind of cancer?			
If so, have you ever received radiation and/or chemotherapy?			
Do you have any conditions that require Pre-Medication?			
If yes, please explain:			
Do you take blood thinners?			
Do you have or have you ever had:			
Respiratory Conditions, including asthma?			
Thyroid problems?			
Epilepsy?			
Stroke?			
High or Low Blood Pressure?			
Pacemaker?			
Heart Disease ?			
Heart Attack?			
Acid Reflux?			
STDs?			
Hepatitis (Please circle) A B C			
HPV?			
HIV/AIDS?			
Do you get cold sores			
Have you been told, or notice, that you snore at night?			
Are you tired, fatigued, or sleepy on most days?			
Drug Allergies? Please list:			
Are you diabetic? If yes, please circle: Type I or Type II			
Is your diabetes well controlled?			
Do you have a sugar source with you at all times?			
Did you know there is a direct link between diabetes and gum disease?			
Women:			
Are you pregnant?			
Are you nursing?			
Are you taking birth control pills?			
Please list all medications you are taking including over the counter medications:			

By signing below you acknowledge you have provided an accurate health history to your dental office. Please keep your dental team informed of any changes in your health as changes can affect your oral health. Additionally, many diseases first symptoms present in the oral cavity and you may be asked to see your medical doctor for diagnosis.

Signature of Patient or Legal Guardian of Patient

Date

Patient Printed Name

Printed Name of Guardian

Provider Reviewed and Date

To be taken by Health Care Professional:

Initial BP _____ and HR_____