DENTAL HISTORY

Why have you come to the dentist today?_____

_____

_____

Circle any conditions you may have:

Cavities	Receding Gums
Tartar Build Up	Missing Enamel
Bleeding Gums	Tooth Wear
Gum Disease	Gaps Between Teeth
Bad Bite	Cracks in Teeth
Broken Teeth	White Spots on Teeth
Chipped Teeth	Bad Breath

Painful/Sensitive Teeth
Stained/Discolored Teeth
Crooked/Malaligned/Crowded Teeth
Crowns, Fillings or Teeth That Don't Fit or Bite Well
Tender/Painful Jaw Joints or Chewing Muscles
Abnormal Color or Growth of Soft Tissues/Gums
Impacting Food Between Teeth
Other?_____

Do you require antibiotics for dental treatment? Y N
Are you currently in pain? Y N
Have you ever had a serious/difficult problem associated with any previous dental work? Y N

Do you now or have you ever had pain/problems with your jaw joint (TMJ/TMD)or chewing muscles? Y N

Do you have headaches? Y N

Do you like your smile? Y N
Do your gums ever bleed? Y N
Have you ever had periodontal disease? Y N
How many times a day do you brush? ____ floss? ____

For Office Use:

Perio Case Type I II III IV___
BP/HR:_____

Joint Noise R _____ L _____
Hx Trauma?_____
Temporal R_____ L_____
Masseter R_____ L_____
Med Pterygoid R_____ L_____
Digastric R_____ L_____
Neck / Shoulder R_____ L_____
Cancer Screening_____
Abfractions_____
Fractures_____
_____
Wear_____
Jaw Function:

MEDICAL HISTORY

Physician's Name:_____Phone:(___)_____
Address(cross streets):_____
Are you taking any drugs or supplements? __Y__N
Please list: _____
_____
_____
_____
_____

Circle Products in your diet:
-Soda/Pop -Mints -Candy/Dessert -Coffee
-Chew unpopped popcorn/ice -Gum -Tea
Do you smoke/use tobacco? __Y__N
#packs/cigars/daily?_____How many years?_____
Have you ever taken bisphosphonates/fosamax? __Y__N
Have you ever had any of the following conditions?

Y N	Anemia/Radiation Treatment	Y N	Abnormal Bleeding
Y N	Artificial Bones/Joints/Valves	Y N	Hepatitis
Y N	Arthritis	Y N	High/Low Blood Pressure
Y N	Asthma	Y N	HIV+/AIDS
Y N	Blood Transfusion	Y N	Hospitalization
Y N	Cancer/Chemotherapy	Y N	Kidney Problems
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Psychiatric Problems
Y N	Difficulty Breathing	Y N	Rheumatic/Scarlet fever
Y N	Drug/ Alcohol Abuse	Y N	Headaches
Y N	Emphysema/Glaucoma	Y N	Shingles
Y N	Epilepsy/Seizures/Fainting	Y N	Sickle Cell
Y N	Fever Blisters/Herpes	Y N	Sinus Problems
Y N	Heart Attack/Stroke	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers/Colitis
Y N	Heart Surgery/Pacemaker	Y N	Venereal Disease
		Y N	Other

Please list any serious medical condition(s) that you have had:
_____
_____
_____

Do you have allergies to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry/Metals	Y N	Tetracycline
Y N	Latex	Y N	Dental Anesthetic	Y N	Other

_____

Women:
Are you using prescription birth control? __Y__N
Are you pregnant? __Y__N Week #?_____
Are you nursing? __Y__N

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____Date_____

I have verbally reviewed Medical/Dental information with patient_____Date_____