Dental History

What is the reason for your visit today?____

Date of Last Dental Visit________________ Last Dental Cleaning________________ Last Full Mouth X-rays________________

What was done at your last dental visit?____

Previous Dentist's Name__________________________________ Telephone #__________________________

How often do you have dental examinations?__________________ Do you have any dental problems now? Yes No

If yes, please describe:____

How often do you brush your teeth?____________________________ How often do you floss?____________________________

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) ________________________________

Are any of your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Other? Yes No

If so where? Yes No

Have you noticed any mouth odor or bad taste? Yes No

Do you frequently get cold sores, blisters or any other lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Have you been diagnosed with gum/ periodontal disease? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? __________________________

Do you have cracked or broken teeth? Yes No

Are you aware of excessively worn teeth? Yes No

Do you:

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects in your teeth? Yes No

Have tired jaws, especially in the morning? Yes No

Have you ever used nitrous "laughing gas"? Yes No

Was the use of "laughing gas" helpful to you? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal Treatment? Yes No

Relapse of orthodontic straightening? Yes No

Your teeth ground or bite adjusted? Yes No

A serious injury to the mouth? Yes No

If so, please describe____________________________

____

A serious injury to the head? Yes No

If so, please describe____________________________

____

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty opening or closing? Yes No

Difficulty chewing? Yes No

Frequent headaches, neck aches, or shoulder aches ? Yes No

Snoring or any other sleep disorders? Yes No

Are you happy with your teeth's appearance? Yes No

Would you like to keep your teeth all your life? Yes No

Do you feel nervous about having dental treatment? Yes No

Have you avoided dental care in the past due to anxiety or fear? Yes No

Have you ever taken a prescription prior to a dental appointment? Yes No If so, what?____________________________

If you could change anything about your dental health or appearance, what would that be (straighter teeth, past dental work, chipped teeth, whiter, teeth, delete space, etc.)?____

Why?____

Are you happy with your past dental treatment? Yes No

If not, what caused your dissatisfaction?____

Is there anything else about having dental treatment that you would like us to know?____________________________

____

Medical History

Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what?____

Physician Name____________________________ Telephone #____________________________

Address____________________________ City__________________ State________ Zip____________

Have you taken any medications or drugs during the past two years? Yes No

If so, what____

Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines?

If yes, please list name and dosage ____

____

Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimen (fenfluramine); and Redux (dexfenfluramine)? Yes No

If yes to the above, did you have a medical exam for heart issues? Yes No

Have you taken any of the following medications (Bisphophonates) for chemotherapy or other reasons? (Circle all that apply)

Alendronate (Fosamax)	Clordronate	Etidronate (Didronel)	Ibandronate (Boniva)
Pamidronate (Aredia)	Resedronate (Actonel)	Tiludronate (Skelid)	Zoledronic Acid (Zometa)

Are you aware of having an allergic (**or adverse**) reaction to any medication or substance? Yes No

If yes, please list____

Have you been a patient in the hospital the past five years? Yes No

If yes, please explain____

Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list:____