

MEDICAL HISTORY

Patient Name _____

Name of Physician/Specialty _____ Reason for Treatment _____

Date of most recent physical examination _____

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

DO YOU HAVE OR HAVE YOU EVER HAD:

	Yes	No		Yes	No		Yes	No
Hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart problem	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Viral infections and cold sores	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Any lumps/swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid or Parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Hives, skin rash, hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hormone deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type_____)	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
A stroke	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Tumor/abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>
Artificial prosthesis (i.e. heart valve or joints)	<input type="checkbox"/>	<input type="checkbox"/>	Digestive disorders	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or other blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged bleeding due to a slight cut	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	Antidepressant medication	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/drug dependency	<input type="checkbox"/>	<input type="checkbox"/>
Breathing/Sleep problems (i.e. snoring, sinus)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>

ARE YOU:

	Yes	No		Yes	No
Presently being treated for any other illness	<input type="checkbox"/>	<input type="checkbox"/>	A smoker or smoked previously	<input type="checkbox"/>	<input type="checkbox"/>
Aware of a change in your general weight	<input type="checkbox"/>	<input type="checkbox"/>	Often unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>
Taking medication for weight management	<input type="checkbox"/>	<input type="checkbox"/>	Often exhausted or fatigued	<input type="checkbox"/>	<input type="checkbox"/>
Taking dietary supplements	<input type="checkbox"/>	<input type="checkbox"/>	Subject to frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
FEMALE - pregnant	<input type="checkbox"/>	<input type="checkbox"/>	MALE – prostate disorders	<input type="checkbox"/>	<input type="checkbox"/>
FEMALE – taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>			

ALLERGIC REACTION TO:

	Yes	No
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>
Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>
Fluoride	<input type="checkbox"/>	<input type="checkbox"/>
Acetaminophen	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Metals (type_____)	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Any other medication	<input type="checkbox"/>	<input type="checkbox"/>

G.A.S.P. Questionnaire

	Yes	No	Not Sure
Have you been told (or noticed on your own) that you snore on most nights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you tired, fatigued or sleepy on most days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you overweight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes Total + <input type="checkbox"/> Not sure Total = <input type="checkbox"/>			
	0	1	2
	3	4	5
	Low Risk	Medium Risk	High Risk

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

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

Drug	Purpose
_____	_____
_____	_____
_____	_____

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

Signature/Guardian _____

Date _____

DENTAL HISTORY

Patient Name _____ SSN _____

Address _____ Phone _____

DOB _____ How did you hear about us? _____ Emergency Contact _____

What would you like your smile to look like in 20 years? _____

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

Previous Dentist _____ How long had you been a patient? _____

Date of most recent dental exam and x-rays _____

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

I routinely see my dentist every: 3 months 6 months 12 months Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PERSONAL HISTORY

	Yes	No
Are you fearful of dental treatment? Scale of 1 to 10 (very)	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an unfavorable dental experience?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had complications from past dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had trouble getting numb or reactions to local anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
Did you ever have braces, orthodontic treatment or had your bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any teeth removed?	<input type="checkbox"/>	<input type="checkbox"/>

SMILE CHARACTERISTICS

Is there anything about the appearance of your teeth that you would like to change?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever whitened (bleached) your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you self conscious about your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been disappointed with the appearance of previous dental work?	<input type="checkbox"/>	<input type="checkbox"/>

BITE AND JAW JOINT

Do you/ would you have any problems chewing gum?	<input type="checkbox"/>	<input type="checkbox"/>
Have your teeth changed in the last 5 years, become shorter, thinner, worn?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth crowding or developing spaces?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have tension headaches or sore teeth?	<input type="checkbox"/>	<input type="checkbox"/>

TOOTH STRUCTURE

Have you had any cavities within the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dry mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Are any teeth sensitive to hot, cold, biting or sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a toothache, cracked filling, or broken, chipped or cracked tooth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel or notice any holes (i.e. pitting) in your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

GUM AND BONE

Have you ever been diagnosed or treated for periodontal (gum) disease?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced gum recession?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when brushing, flossing or eating?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth becoming loose?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed an unpleasant taste or odor in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>

Signature _____ Date _____

Relationship to patient _____

