Dental History Cont. - Please mark (x) any of the following conditions that apply to you

Patient Name (print) _____

Appearance

- ☐ Discolored teeth
- ☐ Worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Spaces
- ☐ Overbite
- ☐ Flat teeth

Pain/Discomfort

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Pressure
- ☐ Broken teeth/fillings
- ☐ Worn teeth
- ☐ Dry Mouth

Function

- ☐ Grinding/Clenching
- ☐ Headaches
- ☐ Jaw Joint (TMJ) pain
- ☐ Jaw Joint (TMJ) clicking/popping
- ☐ Bad Bite
- ☐ Speech Impediment
- ☐ Mouth Breathing
- ☐ Sore Muscles (neck, shoulders)
- ☐ Difficulty Opening or Closing
- ☐ Difficulty Chewing on either side

Periodontal (Gum) Health

- ☐ Bleeding, Swollen, Irritated gums
- ☐ Bad breath
- ☐ Loose tipped, shifting teeth
- ☐ Previous perio/gum disease

Habits

- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/Lip biting
- ☐ Chewing on ice/foreign objects

Sleep Pattern or Conditions

- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Daytime Drowsiness
- ☐ Bed wetting (for children)

Social

Tobacco
How much _____How long _____

Alcohol Frequency_____

Drugs Frequency _____

Previous Comfort Options

- ☐ Nitrous Oxide
- ☐ Oral Sedation (Pill)
- ☐ IV Sedation

Please list family history of any conditions marked:

_____

_____

_____

_____

_____

_____

_____

Medical History - Please mark (x) to your response to indicate if you have or have had any of the following

Cancer

Type _____

- ☐ Chemotherapy
- ☐ Radiation Therapy

Cardiovascular

- ☐ Angina (chest pain)
- ☐ Artificial Heart Valve
- ☐ Heart Conditions
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke

Endocrinology

- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease

Gastrointestinal

- ☐ Ulcers (Stomach)
- ☐ Gastrointestinal Disease

Hematologic/Lymphatic

- ☐ Anemia
- ☐ Blood Disorders
- ☐ Bruise Easily
- ☐ Excessive Bleeding

Musculoskeletal

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Jaw Joint Pain
- ☐ Rheumatoid Arthritis

Neurological

- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Drug/Alcohol Addiction
- ☐ Fainting
- ☐ Seizures
- ☐ Psychiatric Illness

Respiratory

- ☐ Asthma
- ☐ Emphysema
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Tuberculosis

Viral Infections

- ☐ AIDS
- ☐ HIV Positive
- ☐ HPV

Women

- ☐ Currently Pregnant
- ☐ Nursing

Medical Allergies

- ☐ Antibiotics (Penicillin/Amoxicillin /Clindamycin)
- ☐ Opioids (Percocet, Oxycodone, Tylenol 3)
- ☐ Latex
- ☐ Local Anesthetics
- ☐ NSAIDs

Other Allergies

- ☐ _____

Additional Comments:

_____

_____

Are you under the care of a physician? Y or N If yes, please explain _____

_____

Physician Name_____Address:_____Phone(____)_____

Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N, If yes please explain _____

_____

_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Y or N If yes, please list all and why, including vitamins, natural or herbal supplements and/or dietary supplements _____

_____

_____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease?
If so, please list medications: _____

Have you ever had surgery? If so, what type: _____

_____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____ _____

Signature of Patient/Legal guardian *Print Name* *Date* *Dentist Signature*

For completion by dentist only | Additional Comments

_____

_____

_____ 0C126