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**Dental History**

(Please check any of the following that apply to you) What would you like to do to improve your smile?

 Sensitivity (hot, cold, sweets, pressure)  Whiten

 Discomfort when chewing  Straighten

 Headaches, earaches, neck pain  Close spaces

 Jaw joint pain  Replace silver fillings with tooth colored fillings

 Teeth or fillings breaking  Repair chipped teeth

 Bad breath/bad taste in mouth  Replace missing teeth

 Bleeding, swollen or irritated gums  Replace old crowns that don’t match other teeth

 Loose, chipped or shifting your mouth

 Grinding or clenching teeth

Do you have or have you ever had any of the following? How long has it been since your last cleaning?

 Dentures  Partial Dentures  Less than 1 yr  1-2 yrs  3-5 yrs  over 5 yrs

 Braces  Periodontal (gum) treatments

What is most important about your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name of previous dentist Phone number City & State

Why did you leave your previous dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Previous dental experiences: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**On a scale of 1 to 10 with 10 being the highest:**

How important is your dental health to you?  1  2  3  4  5  6  7  8  9  10

Where would you rate your current dental health?  1  2  3  4   5  6  7  8  9 10

**Sleep History**

Have you ever had a sleep study or do you currently use a CPAP? Yes No

Does your partner say that you snore? Yes No

Do you take frequent naps during the day, or often feel tired? Yes No

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

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

 If yes, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last visit to Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have high blood pressure? Yes No What is your normal blood pressure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you allergic or have you had a reaction to the following:**

Local Anesthetic Yes No

Penicillin or other antibiotics Yes No

Aspirin, Ibuprofen or Tylenol Yes No

Codeine, Valium or other sedatives Yes No

Latex or metals Yes No

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Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? Yes No

 If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications, drugs or pills? Yes No

 If yes, please list name and dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you use tobacco? Chew smoke How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consume alcohol? Yes No How many beverages per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any mood altering drugs other than those previously listed? Yes No

**Have you had or now have the following conditions or treatments:**

AIDS Yes No Heart condition Yes No

Alcoholism Yes No Heart murmur Yes No

Allergies or hives Yes No Heart pacemaker Yes No

Asthma Yes No Heart surgery Yes No

Arthritis/Rheumatism Yes No Hemophilia Yes No

Artificial heart valve Yes No Hepatitis type \_\_\_\_\_\_ Yes No

Artificial joints Yes No High blood pressure Yes No

Bleeding/Blood disorder Yes No HIV positive Yes No

Blood thinners/Aspirin Yes No HPV Yes No

Bone disease or bone cancer Yes No Kidney trouble Yes No

Bruise easily Yes No Latex sensitivity Yes No

Cancer Yes No Liver disease Yes No

Chemotherapy Yes No Milk/Casein allergy Yes No

Chest pain (Angina) Yes No Mitral valve prolapse Yes No i

Chronic cough Yes No Neurological disorders Yes No

Cold sores/Fever blisters Yes No Nervous/Anxious Yes No

Congenital heart disease Yes No Osteoporosis Yes No

Contact lenses Yes No Psychiatric/Psychological care Yes No

Cortisone medicine Yes No Radiation therapy Yes No

Diabetes Yes No Rheumatic fever Yes No

Drug addiction Yes No Sinus trouble Yes No

Emphysema Yes No Sleep apnea/Snoring Yes No

Epilepsy or seizures Yes No Stroke Yes No

Fainting or dizzy spells Yes No Thyroid problems Yes No

Family history of diabetes Yes No Tuberculosis (T.B.) Yes No

Glaucoma Yes No Tumors Yes No

Heart attack Yes No Ulcers/Reflux Yes No

Any disease, condition or problem not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women**

Are you pregnant or planning a pregnancy? Yes No Are you a nursing mother? Yes No

 If yes, due date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you taking birth control pills? Yes No

Patient/Parent signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_