

DENTAL HISTORY

Do you like your smile? _____ Yes ___ No	Pain in your jaw joints _____ Yes ___ No
Do you wish your teeth were whiter? _____ Yes ___ No	Popping or clicking in jaw joints _____ Yes ___ No
Would you change your smile if you could? _____ Yes ___ No	Did you ever wear braces? _____ Yes ___ No
Your current dental health is: _____ Good ___ Fair ___ Poor	Frequent dry mouth _____ Yes ___ No
When was your last dental visit? _____	Breath problems _____ Yes ___ No
How many times a week do you brush? _____ and floss? _____	Unpleasant tastes in mouth _____ Yes ___ No
Would you like to learn how to control dental disease _____ Yes ___ No	Headaches _____ Yes ___ No
Do you avoid any part of your mouth while brushing? _____ Yes ___ No	Ear congestion _____ Yes ___ No
Where? _____	Dizziness _____ Yes ___ No
	Ringing in the ears _____ Yes ___ No
Do you have any of the following:	Trouble swallowing _____ Yes ___ No
Nervousness about dental treatment _____ Yes ___ No	Facial pain _____ Yes ___ No
Problems with past dental work/care _____ Yes ___ No	Cervical (neck) pain _____ Yes ___ No
Difficulty chewing _____ Yes ___ No	Postural problems _____ Yes ___ No
Limited opening _____ Yes ___ No	Tingling in fingertips _____ Yes ___ No
Loose Teeth _____ Yes ___ No	Trigeminal Neuralgia _____ Yes ___ No
Tooth Clenching _____ Yes ___ No	Bell's Palsy _____ Yes ___ No
Tooth Grinding _____ Yes ___ No	Nervousness/Insomnia _____ Yes ___ No
Tender / Sensitive teeth _____ Yes ___ No	Do any of your family members currently wear dentures? _____ Yes ___ No
Fillings that show when smiling _____ Yes ___ No	Are you currently in pain? _____ Yes ___ No Where? _____
Bleeding gums _____ Yes ___ No	
Food catching between teeth _____ Yes ___ No	

MEDICAL HISTORY

Your **current** health is: _____ Good ___ Fair ___ Poor
 Are you currently under the care of a physician? _____ Yes ___ No Physician's Name _____ Phone _____
 Last appointment with your physician: _____
 Are you currently taking any prescription, or over the counter drugs? _____ Yes ___ No
Please list _____

For women: Are you pregnant? _____ Yes ___ No
 Are you nursing? _____ Yes ___ No
 Are you taking birth control pills? _____ Yes ___ No

Do you have or have you ever had any of the following medical problems? If so please check.

___ Heart Disease	___ Hemophilia	___ Lung Disease	___ Retinal Surgery	Family History of:
___ Stroke	___ Anemia	___ Tuberculosis	___ Shingles	
___ Heart Attack	___ Diabetes	___ Emphysema	___ Cancer/ Tumors	
___ Heart Murmur	___ Hypo/ Hyperglycemia	___ Breathing Problems	___ Chemotherapy	
___ Mitrovalve Prolapse	___ Thyroid Problems	___ Asthma	___ Radiation	
___ Heart Surgery	___ Endocrine Problems	___ Sinus Problems	___ Epilepsy	
___ Pacemaker	___ Liver Disease	___ Epstein Barr Virus	___ Seizures	
___ Artificial Valve	___ Hepatitis	___ Stomach Problems	___ Fainting Problems	
___ Congenital Heart defect	___ Jaundice	___ Intestinal Problems	___ Dizziness	
___ Rheumatic Fever	___ Kidney Disease	___ Artificial Joints	___ Headache Problems	
___ High/Low Blood Pressure	___ Venereal Disease	___ Fever Blisters/ Cold Sores	___ Migraines	
___ Blood Disease	___ HIV or AIDS	___ Canker sores	___ Glaucoma	
___ Osteoarthritis		___ Osteoporosis	___ Psychiatric Disorders	
___ Rheumatoid Arthritis		___ Sleep problems	___ Drug/ Alcohol Dep.	

Is there ANYTHING else we should know about your health history? _____

Other comments: _____

Have you been hospitalized for any reason? _____ Yes ___ No Why? _____

Have you ever been in the emergency room? _____ Yes ___ No Why? _____

Are you allergic to any of the following? If so, please check.

___ Penicillin	___ Ibuprofen (Motrin)	___ Acetaminophen	___ Latex
___ Erythromycin	___ Aspirin	(Tylenol)	___ Metals (Cosmetic Jewelry)
___ Tetracycline	___ Codeine	___ Sulfa drugs	

Any other drugs or materials not listed above? _____

What type of reaction? _____

Do you smoke? _____ Yes ___ No If so, how many packs per day? _____ How many years? _____

Do you snore? _____ Yes ___ No

Baseline Blood Pressure (Doctor Only) _____

Doctor's signature (reviewed History) _____ Date _____

CHANGE IN HEALTH HISTORY?: DATE / INITIALS: _____ DATE / INITIALS: _____ DATE / INITIALS: _____