

**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
<b>Do you have any of the following:</b>	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	<b>Family History of:</b>
___ 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: \_\_\_\_\_