DENTAL HISTORY

Chief Oral Complaint _____

Date of last dental exam _____ Any previous major dental treatment, ❑ YES ❑ WHEN_____

Are you currently missing any teeth? _____

Would you like information about dental implants to replace missing teeth?_____

INDICATE WITH A (✓) WHERE APPROPRIATE

- ❑ Teeth sensitive to cold, heat, sweets or pressure
- ❑ Bleeding gums. How long _____
- ❑ Food impaction
- ❑ Clenching or grinding
- ❑ Burning of tongue
- ❑ Frequent blisters on lips or mouth
- ❑ Swelling or lumps in mouth
- ❑ Pain around ear
- ❑ Unusual sounds in ear while eating
- ❑ Bad breath
- ❑ Unpleasant taste
- ❑ Unfavorable dental experience
- ❑ Complications from extractions
- ❑ Periodontal treatment
- ❑ Mouth breathing
- ❑ Orthodontic treatment
- ❑ Oral habits, i.e. fingernail biting
- ❑ Cheek biting, etc.
- ❑ Cigarettes, pipe or cigar smoking
- ❑ Texture of toothbrush _____
- ❑ Frequency of brushing _____
- ❑ Dental Floss
- ❑ Interdental stimulators
- ❑ Water jet device
- ❑ Disclosing tablets or solution
- ❑ Fluoride supplements

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical Exam_____ Age _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? - INDICATE WITH A (✓)

- ❑ Allergies to drugs
- ❑ Allergies to anesthetics
- ❑ Any heart ailments
- ❑ High blood pressure
- ❑ Neurological problems
- ❑ Radiation treatments
- ❑ Excessive bleeding from cut or extraction
- ❑ Anemia or blood problems
- ❑ Arthritis
- ❑ Lung disease
- ❑ Pneumonia
- ❑ Pre-medicate for dental procedures
- ❑ Chronic cough
- ❑ Asthma
- ❑ Hay fever or allergies in general
- ❑ Diabetes
- ❑ Kidney problems
- ❑ Liver problems
- ❑ Malignancies
- ❑ Psychiatric care - emotional problems
- ❑ Rheumatic fever
- ❑ Sinus problems
- ❑ Glaucoma
- ❑ Tuberculosis
- ❑ Lung disorders
- ❑ Stroke
- ❑ Thyroid
- ❑ Eye disorders
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer or collitis
- ❑ Pregnancy, (if so) what month_____
- ❑ Venereal disease
- ❑ Convulsions
- ❑ Epilepsy

Describe any current medical treatment including drugs taken, even though not listed above _____

_____

YES NO

- ❒ ❒ Do you pre-medicate for dental procedures and if so, due to what condition? _____
- ❒ ❒ Have you had any serious illnesses? _____
- Are you under the care of a physician at present?
- ❒ ❒ If so, for what? _____
- Have you been under a physician's care in the past six months?
- ❒ ❒ If so, for what? _____
- Are you taking any medicines now or in the past year?
- ❒ ❒ If so, please list _____
- Are you allergic to any medicines or drugs?
- ❒ ❒ If so, please list _____
- ❒ ❒ Are you subject to fainting, dizziness or nervous disorders? _____
- ❒ ❒ Have you ever had complications from taking local anesthesia? _____
- Have you had any operations?
- ❒ ❒ If so, please list _____
- ❒ ❒ Have you ever had a blood transfusion?
- ❒ ❒ Do you presently wear contact lenses?
- ❒ ❒ Do you take aspirin daily?
- ❒ ❒ Are you taking or have you ever taken any bone density medication or bisphosphonates (ex. Fosamax, Boniva, Actonel)