

Patient Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ DOB \_\_\_\_\_

Name of Physician/and their specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health?  Excellent  Good  Fair  Poor

DO YOU HAVE or HAVE YOU EVER HAD:		YES	NO	Height _____	Weight _____	YES	NO
1.	hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
2.	an allergic or bad reaction to any of the following: <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine _____ <input type="checkbox"/> penicillin _____ <input type="checkbox"/> erythromycin _____ <input type="checkbox"/> tetracycline _____ <input type="checkbox"/> sulfa _____ <input type="checkbox"/> local anesthetic _____ <input type="checkbox"/> fluoride _____ <input type="checkbox"/> chlorhexidine (CHX) _____ <input type="checkbox"/> iodine _____ <input type="checkbox"/> metals (nickel, gold, silver, _____) <input type="checkbox"/> latex _____ <input type="checkbox"/> nuts _____ <input type="checkbox"/> fruit _____ <input type="checkbox"/> milk _____ <input type="checkbox"/> red dye _____ <input type="checkbox"/> other _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
3.	heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
4.	history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
5.	artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
6.	pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
7.	orthopedic (e.g., joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
8.	heart murmur, rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
9.	high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
10.	a stroke or take blood thinners _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
11.	anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
12.	prolonged bleeding due to a slight cut (or bruise easily) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
13.	pneumonia, emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
14.	chronic ear infections, tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
15.	breathing problems (e.g., asthma, stuffy nose, sinus congestion) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
16.	sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
17.	kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
18.	liver disease or jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
19.	vertigo (e.g., "the room is spinning") _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
20.	thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
21.	hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
22.	high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
23.	diabetes (HbA1c = _____ ) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
24.	stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
25.	digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
26.	osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
27.	arthritis or gout _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
28.	autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
29.	glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
30.	contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
31.	head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
32.	epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
33.	neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
34.	viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
35.	any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
36.	hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
37.	STI/STD/HPV _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
38.	hepatitis (type _____ ) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
39.	HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
40.	tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
41.	radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
42.	chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
43.	psychiatric treatment, antidepressants, mood stabilizing medications _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
44.	concentration problems or ADD/ADHD _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
45.	alcohol/recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>ARE YOU:</b>							
46.	presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
47.	aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
48.	taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
49.	taking dietary supplements, vitamins, and/or probiotics _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
50.	often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
51.	experiencing frequent headaches or chronic pain _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
52.	a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
53.	often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
54.	using birth control pills/patch etc. _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
55.	currently pregnant /expected due date: _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
56.	diagnosed with a prostate disorder _____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) \_\_\_\_\_

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# DENTAL HISTORY

Referred by \_\_\_\_\_ How would you rate the condition of your mouth?  Excellent  Good  Fair  Poor

Previous Dentist \_\_\_\_\_

Date of most recent dental exam \_\_\_/\_\_\_/\_\_\_ Date of most recent x-rays \_\_\_/\_\_\_/\_\_\_

Date of most recent treatment (other than a cleaning) \_\_\_/\_\_\_/\_\_\_

I routinely see my dentist every  3 mo.  4 mo.  6 mo.  12 mo.  Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? \_\_\_\_\_

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:**

**PERSONAL HISTORY**

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [\_\_\_\_] \_\_\_\_\_
2. Have you had an unfavorable dental experience? \_\_\_\_\_
3. Have you ever had complications from past dental treatment? \_\_\_\_\_
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? \_\_\_\_\_
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? \_\_\_\_\_

**YES NO**

- |                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

**GUM AND BONE**

7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? \_\_\_\_\_
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? \_\_\_\_\_
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? \_\_\_\_\_
10. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? \_\_\_\_\_
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? \_\_\_\_\_
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? \_\_\_\_\_

**YES NO**

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| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

**TOOTH STRUCTURE**

14. Have you had any cavities within the past 3 years? \_\_\_\_\_
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? \_\_\_\_\_
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? \_\_\_\_\_
18. Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_
20. Do you frequently get food caught between any teeth? \_\_\_\_\_

**YES NO**

- |                          |                          |
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**BITE AND JAW JOINT**

21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking? \_\_\_\_\_
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together? \_\_\_\_\_
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? \_\_\_\_\_
25. Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_
26. Are your teeth developing spaces or becoming more loose? \_\_\_\_\_
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? \_\_\_\_\_
28. Do you place your tongue between your teeth or close your teeth against your tongue? \_\_\_\_\_
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore? \_\_\_\_\_
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? \_\_\_\_\_
32. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_

**YES NO**

- |                          |                          |
|--------------------------|--------------------------|
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**SMILE CHARACTERISTICS**

33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)? \_\_\_\_\_
34. Have you ever bleached (whitened) your teeth? \_\_\_\_\_
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? \_\_\_\_\_
36. Have you been disappointed with the appearance of previous dental work \_\_\_\_\_
37. Are you interested in cosmetic procedures/products? (i.e. Botox) \_\_\_\_\_

**YES NO**

- |                          |                          |
|--------------------------|--------------------------|
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| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_