MEDICAL HISTORY

Print Form

Name of Physician and their speciality: _____

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
1. Hospitalization for illness or injury? _____	☐	☐
2. An allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen		
☐ penecillin		
☐ erythromycin		
☐ tetracyclin		
☐ codiene		
☐ local anaesthetic		
☐ fluoride		
☐ metals (gold, nickel, stainless steel)		
☐ latex		
☐ any other _____		
3. heart problems _____	☐	☐
4. heart murmur _____	☐	☐
5. rheumatic fever _____	☐	☐
6. scarlet fever _____	☐	☐
7. high blood pressure _____	☐	☐
8. low blood pressure _____	☐	☐
9. a stroke _____	☐	☐
10. artificial prosthesis (i.e. heart valve, or joints) ___	☐	☐
11. anemia or other blood disorders _____	☐	☐
12. prolonged bleeding due to a slight cut _____	☐	☐
13. emphysema _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. kidney disease _____	☐	☐
17. liver disease _____	☐	☐
18. thyroid or parathyroid disease _____	☐	☐
19. hormone deficiency _____	☐	☐
20. high cholesterol _____	☐	☐
21. diabetes _____	☐	☐
22. Stomach or duodenal ulcer _____	☐	☐
23. digestive disorders (i.e. gastric reflux) _____	☐	☐
24. osteoporosis (i.e. taking bisphosphonates) _____	☐	☐
25. arthritis _____	☐	☐
26. glaucoma _____	☐	☐
27. head or neck injuries _____	☐	☐
28. epilepsy, convulsions(seisures) _____	☐	☐
29. neurologic problems _____	☐	☐
30. viral infections and cold sores _____	☐	☐
31. any lumps or swelling in the mouth _____	☐	☐
32. venereal disease _____	☐	☐
33. hepatitis - type _____	☐	☐
34. HIV/AIDS _____	☐	☐
35. tumor, abnormal growth _____	☐	☐
36. radiation therapy _____	☐	☐
37. chemotherapy _____	☐	☐
38. emotional or psychiatric treatment _____	☐	☐
39. antidepressant medication _____	☐	☐
40. snoring or sleep apnea _____	☐	☐
41. alcohol / drug dependancy _____	☐	☐
ARE YOU		
42. presently being treated for any other illness ____	☐	☐
43. aware of a change in your general health _____	☐	☐
44. taking dietary supplement _____	☐	☐
45. often exhausted or fatigued _____	☐	☐
46. subject to frequent headaches _____	☐	☐
47. a smoker or smoked previously _____	☐	☐
48. often unhappy or depressed _____	☐	☐
49. FEMALE - taking birth control pills _____	☐	☐
50. FEMALE - pregnant _____	☐	☐
51. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

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

	Drug	Purpose		Drug	Purpose
1.			3.		
2.			4.		

I authorize and give consent to preform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthetic and other medication as indicated. I certify to the statements regarding my medical conditions.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Print Form

Referred by:_____ How would you rate the condition of your mouth? ☐ Excellent ☐ Poor ☐ Fair ☐ Good

Previous Dentist_____ How long have you been a patient?_____ Date of most recent exam?_____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo ☐ Not routinely Date of most recent cleaning?_____

What is your immediate concern? _____

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

PERSONAL HISTORY

1. Have you had an unfavourable dental experience? _____ ☐ ☐
2. Have you ever had complications from past dental treatment? _____ ☐ ☐
3. Have you ever had trouble getting numb or reactions to local anesthetic? _____ ☐ ☐
4. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
5. Have you had any teeth removed? _____ ☐ ☐

SMILE CHARACTERISTICS

6. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
7. Have you ever whitened (bleached) your teeth? How? _____ ☐ ☐
8. Are you self concious about your teeth? _____ ☐ ☐
9. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT

10. Do you / would you have any problems chewing gum? _____ ☐ ☐
11. Do you / would you have any problems chewing bagels or other hard foods? _____ ☐ ☐
12. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
13. Are your teeth crowding or developing spaces? _____ ☐ ☐
14. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____ ☐ ☐
15. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
16. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
17. Do you have tension headaches or sore teeth? _____ ☐ ☐
18. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

TOOTH STRUCTURE

19. Have you had any cavities within the last 3 years? _____ ☐ ☐
20. Are any teeth sensitive to hot, cold, biting or sweets? _____ ☐ ☐
21. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____ ☐ ☐
22. Do you avoid brushing any part of your mouth? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting) in your teeth? _____ ☐ ☐

GUM AND BONE

24. Have you ever been diagnosed or treated for periodontal (gum) disease? _____ ☐ ☐
25. Have you ever experienced gum recession? _____ ☐ ☐
26. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
27. Do your gums bleed when brushing, flossing or eating? _____ ☐ ☐
28. Are your teeth becoming loose? _____ ☐ ☐
29. Have you ever noticed an unpleasant taste or odour in your mouth? _____ ☐ ☐
30. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____