

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

DENTAL HISTORY

1. Reason for visit: _____
 2. When was your last dental visit? _____
 3. How often do you brush your teeth? _____
 4. What texture brush do you use? Soft Medium Hard
- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 5. Do your gums bleed while brushing? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any head, neck, or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do your gums bleed when flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you feel pain to any of your teeth when brushing or flossing them? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you clench or grind your teeth while awake or asleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you noticed any loosening of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Have you ever had: | | |
| | | | a. Orthodontic treatment (braces)? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b. Oral surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c. Gum treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | d. Your teeth ground or the bite adjusted? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | e. Worn a bite plane or other appliance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does food tend to become caught between your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Are you satisfied with the appearance of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have you ever had an upsetting experience in the dental office? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever experienced any of the following problems in your jaw? | | | 20. Is there anything about having dental treatment that bothers you? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Clicking? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| b. Pain (joint, ear, side, face) ? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| c. Difficulty in opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| d. Difficulty in chewing? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems That you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you ever had any abnormal bleeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health within the last year? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Date of your last physical exam:
_____ | | | 10. Have you ever required a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Physician information
Name: _____
Address: _____
Phone #: _____ | | | 11. Have you had a recent weight loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you now under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been hospitalized for any surgical operation or serious illness?
Please Explain: _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you use alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 14. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 15. Do you have any disease, condition or problem you think I should know about?

_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you taking any medicine(s) including non-prescription medicine?
If yes, what medicine(s) are you taking?

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

Women Only:

1. Are you pregnant or think you may be pregnant?
2. Are you nursing?
3. Are you taking birth control pills?

(OVER)

