MEDICAL and DENTAL HISTORY

Date: _____

Name of Patient: _____ Age: _____ Birth Date: _____

Physician: _____
Name City/State Phone Number

Former Dentist: _____
Name City/State Phone Number

Date of Last Dental Exam: _____ Were any x-rays taken within the last year ? Yes☐ No☐

Dental History

1. Do you have any dental problems or concerns at this time? Yes☐ No☐
   If yes, please complete: Where? _____ For How Long? _____
   Describe Symptoms _____
2. Are your teeth sensitive?..... Yes / No
3. Do you have any concerns about your gums?..... Yes / No
4. Can you chew comfortably?..... Yes / No
5. Are you happy with the appearance of your teeth?..... Yes / No
   Would you like information on whitening?..... Yes / No
   Would you like a smile analysis? (Evaluate tooth shape, position, color and smile symmetry)..... Yes / No
6. Have you ever had problems with local anesthesia (such as novocaine)?..... Yes / No
7. Have you ever had problems with dental treatment in the past?..... Yes / No
8. Is there anything special we can do to make your dental experience more comfortable? Yes / No

Headache History

Do you get headaches?..... Yes / No
How often do you get headaches ? _____
Where is the pain located ? _____
Please indicate your typical level of pain (low) 1 2 3 4 5 6 7 8 9 10 (high)
Have the headaches been diagnosed? Sinus☐ Muscular☐ Vascular☐ Migraine☐ Stress☐
If not diagnosed, what do you think is the cause? _____
Have you used any medication? _____
Have other treatments been tried? _____

TMJ

1. Pain in the joint itself?..... No / Yes..... Right..... Left..... Both
2. Clicking / Popping?..... No / Yes..... Right..... Left..... Both
3. Grating sound?..... No / Yes..... Right..... Left..... Both
4. How long have the symptoms been present? _____
5. Are your symptoms intermittent or constant? _____
6. Have your symptoms gotten better or worse? _____
7. Does anything make them worse? _____
8. Have you ever had a limitation of opening or closing your mouth?..... Yes / No
9. Have you had TMJ symptoms evaluated in the past? ..... Yes / No

Do you wish to use sedation for your treatment? ($49-hr, usually not covered by insurance) Yes ❍ No ❍

(please also complete second page)

Medical/Dental History Continued (page 2)

Patient's Name _____

Physician _____ Location/Phone _____

Have you ever had any of the following diseases or medical problems? Please Circle Y(Yes) N(No)

Y	N	Arrhythmia / Pacemaker	Y	N	Anemia
Y	N	Prosthetic Heart Valves / Stents	Y	N	Cancer / Chemotherapy / Radiation
Y	N	Heart Murmur / Mitral Valve Prolapse	Y	N	Diabetes / A1C
Y	N	Heart Attack / Angina	Y	N	Kidney Disease
Y	N	A – V Shunt / CSF Shunt	Y	N	Hepatitis: A, B, C
Y	N	Central IV Catheter (Hickman)	Y	N	Stomach Ulcers / Irritable Bowel Syndrome
Y	N	High / Low Blood Pressure	Y	N	Sinus Problems
Y	N	Rheumatic Fever / Scarlet Fever	Y	N	Thyroid Disorder
Y	N	Organ Transplant / Asplenia (no spleen)	Y	N	Venereal Disease
Y	N	Artificial Joints	Y	N	Psychiatric Problems / Chronic Depression
Y	N	Implants: What type?	Y	N	Severe or Frequent Headaches / Migraines
Y	N	Stroke / TIA	Y	N	Drug / Alcohol Abuse
Y	N	Emphysema / Respiratory Problems	Y	N	Canker Sores
Y	N	Asthma	Y	N	Cold Sores
Y	N	Allergies: What kind?	Y	N	HIV / AIDS
Y	N	Tuberculosis	Y	N	Epilepsy / Seizure / Fainting Spells
Y	N	Autoimmune Disorders / Lupus	Y	N	Recent Surgery
Y	N	Prolonged Bleeding / Blood Thinners / INR	Y	N	Osteoporosis /Osteopenia /Bone altering Med
Y	N	Hemophilia / Abnormal Bleeding	Y	N	Tobacco Use: What type?

Please note any additional serious illnesses or conditions you have had not indicated above :

_____

Do you take medications, vitamins, herbs, over-the-counter medicines ?
Please list (Use back of page if necessary.):

_____ _____ _____

Are you allergic to any of the following ? Please circle Y (Yes) or N (No):

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Sulfa
Y	N	Codeine	Y	N	Latex	Y	N	Sedatives
Y	N	Dental Anesthetics	Y	N	Penicillin	Y	N	Tetracycline

Please list any *other* drugs or supplements that you are allergic to:_____

♀ **For Women**: Are you pregnant? Yes ❍ No ❍ Are you nursing? Yes ❍ No ❍
Are you currently taking oral contraceptives? Yes ❍ No ❍

Thank you for taking the time to complete your health history. We will hold this information in the strictest confidence. This vital information will help us provide you with the best possible care. I understand that the information I have given today is correct, to the best of my knowledge:

Sign_____Date_____

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