MEDICAL HISTORY

Patient Name: Nickname: Age:

Name of Physician / and their speciality:

Most recent physical examination: Purpose:

What is the estimate or your general healthy: ☐ 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		
☐ Penicillin		
☐ Erythromycin		
☐ Tetracycline		
☐ Codeine		
☐ Local anesthetic		
☐ Fluoride		
☐ Metals (gold, stainless steel)		
☐ Latex		
☐ Any other medications		
3 Heart problems	☐	☐
4 Heart murmer	☐	☐
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 disorder	☐	☐
12 Prolonged bleeding due to a slight cut	☐	☐
13 Emphysema	☐	☐
14 Tuberculosis	☐	☐
15 Asthma	☐	☐
16 Breathing or sleep problems (i.e. snoring, sinus)	☐	☐
17 Kidney disease	☐	☐
18 Liver disease	☐	☐
19 Jaundice	☐	☐
20 Thyroid or parathyroid disease	☐	☐
21 Hormone deficiency	☐	☐
22 High cholesterol	☐	☐
23 Diabetes	☐	☐
24 Stomach or duodenal ulcer	☐	☐
25 digestive disorders (i.e. gastric reflux)	☐	☐

	YES	NO
26 Osteoporosis, osteopenia (i.e. taking bishosphonates)	☐	☐
27 Arthritis	☐	☐
28 Glaucoma	☐	☐
29 Contact lenses	☐	☐
30 Head or neck injuries	☐	☐
31 Epilepsy, convulsions (seizures)	☐	☐
32 Neurologic problems	☐	☐
33 Viral infections and cold sores	☐	☐
34 Any lumps or swelling in the mouth	☐	☐
35 Hives, skin rash, hay fever	☐	☐
36 Venereal disease	☐	☐
37 Hepatitis (type)	☐	☐
38 HIV / AIDS	☐	☐
39 Tumor, abnormal growth	☐	☐
40 Radiation therapy	☐	☐
41 Chemotherapy	☐	☐
42 Emotional problems	☐	☐
43 Psychiatric treatment	☐	☐
44 Antidepressant medication	☐	☐
45 Alcohol / drug dependency	☐	☐
ARE YOU		
46 Presently being treated for any other illness	☐	☐
47 Aware of a change in your general health	☐	☐
48 Taking medication for weight management (i.e. fen-phen)	☐	☐
49 Taking dietary supplements	☐	☐
50 Often exhausted or fatigued	☐	☐
51 Subject to frequent headaches	☐	☐
52 A smoker or smoked previously	☐	☐
53 Considered a touchy person	☐	☐
54 Often unhappy or depressed	☐	☐
55 FEMALE - Taking birth control pills	☐	☐
56 FEMALE - Pregnant	☐	☐
57 MALE - Prostate disorders	☐	☐

LIST ALL MEDICATIONS, SUPPLEMENTS, AND OR VITAMINS TAKEN WITHIN THE LAST TWO YEARS

DRUG	PURPOSE

Ask for an additional sheet if you are taking more than 6 medications - 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: How long have you been a patient? Months / Years

Date of most recent dental exam: / / Date of most recent x-rays: / /

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:	**YES**	**NO**
PERSONAL HISTORY			
1	Are you fearful of dental treatment? Scale of 1 (not at all) to 10 (very)	☐	☐
2	Have you had an unfavourable dental experience?	☐	☐
3	Have you ever had complications from past dental treatment?	☐	☐
4	Have you ever had trouble getting numb or reactions to local anesthetics?	☐	☐
5	Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6	Have you had any teeth removed?	☐	☐
SMILE CHARACTERISTICS			
7	Is there anything about the appearance of your teeth that you would like to change?	☐	☐
8	Have you ever whitened (bleached) your teeth?	☐	☐
9	Are you self conscious about your teeth?	☐	☐
10	Have you been disappointed with the appearance of previous dental work?	☐	☐
BITE AND JAW JOINT			
11	Do you / would you have any problems chewing gum?	☐	☐
12	Do you / would you have any problems chewing bagels or other hard foods?	☐	☐
13	Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
14	Are your teeth crowding or developing spaces?	☐	☐
15	Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	☐	☐
16	Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
17	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
18	Do you have tension headaches or sore teeth?	☐	☐
19	Do you wear or have you ever worn a bite appliance?	☐	☐
TOOTH STRUCTURE			
20	Have you had any cavities within the past 3 years?	☐	☐
21	Do you have a dry mouth?	☐	☐
22	Are any teeth sensitive to hot, cold, biting or sweets?	☐	☐
23	Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	☐	☐
24	Do you avoid brushing any part of your mouth?	☐	☐
25	Do you feel or notice any holes (i.e. pitting) in your teeth?	☐	☐
GUM AND BONE			
26	Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
27	Have you ever experienced gum recession?	☐	☐
28	Is there anyone with a history of periodontal disease in your family?	☐	☐
29	Do your gums bleed when brushing, flossing or eating?	☐	☐
30	Are your teeth becoming loose?	☐	☐
31	Have you ever noticed an unpleasant taste or odour in your mouth?	☐	☐
32	Have you experienced a burning sensation in your mouth?	☐	☐

Patient's Signature:	DATE:
Doctor's Signature:	DATE: