Dental Health History

Date of your last visit to the dentist _____ Last check-up/cleaning _____
Name of former dentist _____
Why did you leave your last dentist? _____
Why did you decide to seek dental care at this time? _____

_____

Has any dental treatment been recommended and not completed? ☐ Yes ☐ No

Are you happy with the appearance of your smile? ☐ Yes ☐ No
How would you rate your dental appearance on a scale from 1 to 10? _____
If there were a safe and inexpensive way to whiten your teeth would you be interested? ☐ Yes ☐ No
Would you be interested in learning more about ways to improve your smile? ☐ Yes ☐ No
If anything were possible, what would you want to change about your smile?

_____

How do you see your teeth in 5 years? _____
How do you see your teeth in 20 years? _____
How would you rate your dental health on a scale from 1 to 10? _____
Do you believe your teeth should last a lifetime? ☐ Yes ☐ No
Within your family is there a high rate of one or more of the following:
___Dental decay (cavities)? ___Lost teeth or dentures? ___Periodontal disease?

Do you have your teeth cleaned on a regular basis? ☐ Yes ____ times a year ☐ No
How often do you brush? _____
How often do you floss? _____
Do your gums bleed? ☐ Yes ☐ No
Have you ever been told you have gum disease? ☐ Yes ☐ No
Have you ever been treated for gum disease? ☐ Yes ☐ No

Do you feel apprehensive about dental treatment? ☐ Yes ☐ No
Have you ever had an unpleasant dental experience? ☐ Yes ☐ No

Do you wear dentures or partial dentures? ☐ Yes ☐ No
Do you clench and/or grind your teeth? ☐ Yes ☐ No
Do you or have you had pain or tenderness in your jaw? ☐ Yes ☐ No
Have you had orthodontic treatment? ☐ Yes ☐ No
If so, when? _____

In the past have any of the following concerns prevented you from having necessary dental treatment?

☐ None ☐ Cost of treatment ☐ Trust in dentist ☐ Other concern
☐ Fear of pain ☐ Missing work ☐ Lack of concern _____

Name: _____

All information is kept in the strictest confidence

1. How would you estimate your general health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent
2. Have you been hospitalized within the last two years? ☐ yes ☐ no
   If yes please explain: _____
3. Are you currently under the care of a physician? ☐ yes ☐ no
   Reason: _____ Date of last visit: _____
   Physician name: _____ Phone number: _____
4. Are you currently taking any prescribed medications, drugs or pills? ☐ yes ☐ no
   If yes, please list name and dose: _____
5. Are you regularly taking any other drugs, medications, or supplements? ☐ yes ☐ no
   If yes, please list name and dose: _____
6. Do you smoke or currently use any tobacco products? ☐ yes ☐ not now, but did in past ☐ never
7. Are you now or have you ever taken oral bisbiophosphonate? (ie.Fosamax, Actonel, Boniva) ☐ yes ☐ no
8. Have you needed in the past to take antibiotics prior to dental treatment? ☐ yes ☐ no
9. The following conditions may indicate the need for antibiotic premedication prior to dental treatment. Please mark any of the following which you have had or have at present.

☐ **NONE APPLY**	☐ Heart Valve Problem	☐ Use of FenPhen/Redux
☐ Artificial Heart Valve	☐ Heart Surgery	☐ Placement of Stents or other Prosthetics
☐ Artificial Joint	☐ Plastic Surgery/Implants	
☐ Heart Murmur	☐ Rheumatic Fever	

DO YOU CURRENTLY HAVE OR HAVE YOU IN THE PAST EXPERIENCED THE FOLLOWING:

☐ yes ☐ no Abnormal Bleeding	☐ yes ☐ no Epilepsy	☐ yes ☐ no Kidney Treatment
☐ yes ☐ no Allergies/Hives	☐ yes ☐ no Fainting / Dizziness	☐ yes ☐ no Psychiatric Treatment
☐ yes ☐ no Anemia	☐ yes ☐ no Food Allergies	☐ yes ☐ no Radiation Treatment
☐ yes ☐ no Arthritis	☐ yes ☐ no Glaucoma	☐ yes ☐ no Sinus Trouble
☐ yes ☐ no Alcoholism	☐ yes ☐ no Headaches	☐ yes ☐ no Stroke
☐ yes ☐ no Asthma	☐ yes ☐ no Head/Neck Injury	☐ yes ☐ no Tuberculosis (TB)
☐ yes ☐ no Bruise Easily	☐ yes ☐ no Heart Attack	☐ yes ☐ no Tumor
☐ yes ☐ no Cancer	☐ yes ☐ no Heart Pacemaker	☐ yes ☐ no Thyroid Disease
☐ yes ☐ no Cold Sores	☐ yes ☐ no Hepatitis/Liver Disease	☐ yes ☐ no Ulcers
☐ yes ☐ no Diabetes	☐ yes ☐ no HIV/AIDS	
☐ yes ☐ no Drug Addiction	☐ yes ☐ no High Blood Pressure	

DO YOU HAVE OR HAVE YOU EVER HAD AN ALLERGY OR ADVERSE REACTION TO:

☐ yes ☐ no Local Anesthetics	☐ yes ☐ no Codeine, Demerol, or other narcotics
☐ yes ☐ no Penicillin or other antibiotics	☐ yes ☐ no Reaction to metals
☐ yes ☐ no Sulfa Drugs	☐ yes ☐ no Latex or Rubber Dam
☐ yes ☐ no Barbiturates or Sedatives	☐ yes ☐ no Other:
☐ yes ☐ no Aspirin, Acetaminophen, Ibuprophen	_____

10. ***Women***: Are you taking contraceptives? ☐ yes ☐ no Are you pregnant? ☐ yes ☐ no

PLEASE PROVIDE ADDITIONAL INFORMATION ABOUT ANY "YES" ANSWERS

_____

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I agree to keep this office informed of any changes in my health or of any medications I may be taking.

☒ Signed: _____ Date: _____