

MEDICAL HEALTH HISTORY

Patient Name _____ Today's Date _____

Date of Birth _____ Sex: M / F Social Security # _____ - _____ - _____

Name of Physician _____ Phone #: (____) _____ - _____ Date of Last Exam _____

Are you under the care of a physician? Yes / No If yes, please explain:

Have you ever been told that you need to premedicate with antibiotics before a dental visit and/or dental treatment?
 YES / NO If so, with what? _____ Why? _____

Allergies and/or reactions to: Penicillin / Codeine / Local Anesthetics / Latex / Other _____

Please list any prescription and over-the-counter medications you are currently taking and why. _____

IF Female:	Yes	No
Are you taking hormones or birth control?		
Are you pregnant or nursing?		
Is there a possibility you may be pregnant?		

Have you ever had or do you currently have any of the following? (Please check appropriate box.)

	Yes	No		Yes	No
AIDS			Glaucoma		
Abnormal Blood Pressure			Heart Attack		
Anemia			Heart Surgery		
Angina			Mitral Valve Prolapse		
Arthritis			Rheumatic Fever		
Artificial Heart Valve			Kidney Trouble		
Artificial Joints			Liver Disease (Hepatitis)		
Asthma			Lung Disease		
Bronchitis			Pacemaker		
Cancer			Stroke		
Chemotherapy			Thyroid Disease		
Congenital Heart Lesions			Tuberculosis		
Diabetes			Radiation Therapy		
Epilepsy			Prolonged Coughing		
Fainting			Prolonged Bleeding		

Dental Health History

Reason for today's visit: _____

When was your last dental visit? _____ What was it for? _____

History

	Yes	No	Dr. Notes
Have you ever had a negative dental experience?			
Have you ever had a toothache or a broken tooth?			
Have you ever had braces (orthodontics)?			
Have you ever had gum treatment (periodontics)?			
Are your teeth sensitive to hot, cold, sweet or sour foods and liquids?			
Do your gums bleed while brushing and/or flossing?			
Do you have a bad taste in your mouth or experience constant bad breath?			
Do you have any sores or lumps in or near your mouth?			
Does food tend to catch in your teeth?			

Habits

	Yes	No
Do you snore?		
Do you use tobacco? If Yes, how much and for how long?		
Do you clench or grind your teeth while awake or asleep?		

Pain/Jaw

	Yes	No
Do you have frequent headaches and earaches?		
Have you ever had any head, neck or jaw injuries?		
Have you experienced any of the following in your jaws? (Please circle all that apply)		
Clicking/Popping	Pain in joint or ear	Difficulty Opening Difficulty Chewing

Please list any medical or dental questions or concerns you may have.

Level of Treatment

We respect your right to choose the level of care that fits your needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth. Please check all that apply.

- I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good and last for a long time.
- Spreading payments out over time may help me to achieve the excellent results I desire.
- Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
- I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
- Although I am not interested in a plan for long-term dental health, I do desire an office that will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.
- I have considered cosmetic dentistry.

COSMETIC / ESTHETIC EVALUATION

Are you delighted with your smile? ___ Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = Awesome)

Would you like to have whiter teeth? Yes No

If you had a magic wand what, if anything would you change about your smile? _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

What changes would you like to see with your smile?

<input type="checkbox"/>	Lighten all front teeth showing
<input type="checkbox"/>	Lighten single tooth
<input type="checkbox"/>	Close spaces between teeth
<input type="checkbox"/>	Rebuild fracture(s)
<input type="checkbox"/>	Lengthen
<input type="checkbox"/>	Shorten
<input type="checkbox"/>	Lighten all front teeth showing
<input type="checkbox"/>	Lighten single tooth

<input type="checkbox"/>	Close spaces between teeth
<input type="checkbox"/>	Straighten rotation
<input type="checkbox"/>	Straighten angulation
<input type="checkbox"/>	Eliminate crowding
<input type="checkbox"/>	Eliminate dark or stained fillings
<input type="checkbox"/>	Reduce gum showing in smile
<input type="checkbox"/>	Repair uneven edges

Please add anything you feel is important: _____
