DENTAL HISTORY

Patient Name_____ **Date of Birth** _____

	Yes	No
Are your teeth sensitive to:		
Heat	□	□
Cold	□	□
Sweets	□	□
Pressure	□	□
Does food catch between your teeth	□	□
Do your gums bleed when brushing	□	□
Have you noticed any gum swelling around teeth	□	□
Do you have an unpleasant taste/odor in your mouth	□	□
Problems of the Jaw:		
Clicking	□	□
Pain (joints, ear, side of face)	□	□
Difficulty opening/closing	□	□
Difficulty chewing	□	□
Do you avoid any part of the mouth while brushing	□	□
Have you had a reaction to a local anesthetic	□	□
Are you dissatisfied with your teeth and their appearance	□	□
If so, please specify:_____		
Are you concerned about the finances required to return your teeth to excellent dental health	□	□
Do you use any tobacco products	□	□
Have you ever had any teeth removed	□	□
How long have they been missing_____		
Do you feel you will eventually wear artificial dentures	□	□
Do you have any dental fears	□	□
Do you have any present dental concerns_____		
_____		
Why did you leave your last dentist _____		
_____		

	Yes	No
When was your last dental exam_____		
Do you have any general health problems	□	□
If so, please specify:_____		
_____		
Have you had surgery	□	□
If so, please specify:_____		
_____		
Are you currently under physician's care	□	□
Reason_____		
Medications_____		
_____		
Have you/are you taking oral bisphosphonates?	□	□
To the best of your knowledge, are/have you ever been afflicted with:		
Heart Ailment_____	□	□
Diabetes	□	□
Rheumatic Fever	□	□
Epilepsy	□	□
Artificial joints	□	□
High Blood Pressure	□	□
Respiratory Disease	□	□
Hepatitis	□	□
HIV positive	□	□
Prolonged bleeding	□	□
Healing Complications	□	□
Allergies To any Drugs	□	□
If so, please specify:_____		
If needed, Which Pharmacy do you prefer?		
_____		
Are you pregnant?	□	□

Signature of Patient_____ **Date** _____

Office Use Only

Date_____BP_____P_____

Notes_____ Medications: Allergies:

_____ _____ _____

_____ _____ _____

Signature of Dr or RDH_____ PREMED (YES OR NO)_____