

# Health and Dental History

Patient Name \_\_\_\_\_ Contact Number \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Are you taking any medication now, including regular doses of Aspirin? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please list the name and dosage \_\_\_\_\_

Are you aware of having an allergic reaction to any medication or substance? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please list \_\_\_\_\_

Have you been under the care of a medical doctor during the past two years? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, for what? \_\_\_\_\_

Have you seen an ENT (ear, nose, throat) Yes \_\_\_\_\_ No \_\_\_\_\_ Dr.'s Name \_\_\_\_\_

Have you seen a chiropractor/? Yes \_\_\_\_\_ No \_\_\_\_\_ Dr.'s Name \_\_\_\_\_

Have you seen a neurologist? Yes \_\_\_\_\_ No \_\_\_\_\_ Dr's.Name \_\_\_\_\_

Have you had braces? Yes \_\_\_\_\_ No \_\_\_\_\_ Dr's.Name \_\_\_\_\_

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Concerns	Yes	No	Pschiatric/Pyscological	Yes	No
Congenital Heart Disease	Yes	No	Jaw Pain	Yes	No
Heart Murmur	Yes	No	Jaw Popping	Yes	No
High Blood Pressure	Yes	No	Limited Opening	Yes	No
Mitral Valve Prolapse	Yes	No	Congested Ears	Yes	No
Rheumatic Fever	Yes	No	Headaches	Yes	No
Artificial Heart Valve	Yes	No	Dizziness	Yes	No
Pacemaker	Yes	No	Ringling in Ears	Yes	No
Stroke	Yes	No	Loose Teeth	Yes	No
Asthma	Yes	No	Posture Problems	Yes	No
Liver Disease/ Jaundice	Yes	No	Clenching	Yes	No
Latex Sensitivity	Yes	No	Grinding	Yes	No
Artificial Joints	Yes	No	Facial Pain	Yes	No
Kidney Trouble	Yes	No	Sensitive Teeth	Yes	No
Radiation\Chemotherapy	Yes	No	Neck Ache	Yes	No
Epilepsy/ Seizures	Yes	No	Bell's Palsy	Yes	No
Diabetes	Yes	No	Difficulty Swallowing	Yes	No
Hepatitis	Yes	No	Difficulty Chewing	Yes	No
AIDS/ HIV	Yes	No	Trigeminal Neuralgia	Yes	No
Sickle Cell Disease	Yes	No	Tingling in arms\ fingers	Yes	No
Neurological Disorders	Yes	No	Insomnia/ Frequent Waking	Yes	No

Women: Are you pregnant? \_\_\_\_\_ Breastfeeding? \_\_\_\_\_ Taking birth control? \_\_\_\_\_

Does floss shred when you use it? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you smoke or chew tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_

Does food pack or catch between your teeth? Yes \_\_\_\_\_ No \_\_\_\_\_ Do your gums bleed or hurt? \_\_\_\_\_

Do you have or have you had any disease, condition, or problems not listed? \_\_\_\_\_

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the health care provider, who may release such information to you. I will notify the doctor of changes in my health or medication.

Signature \_\_\_\_\_ Date \_\_\_\_\_

We are committed to providing the best care possible. For us to do this we need you to think about the following questions, so that we can better assist you in addressing your dental needs.

Are you having any areas of concern? \_\_\_\_\_

Tell us, in your opinion, what you think the present state of the health of your mouth is?  
\_\_\_\_\_

What do you already know about our office and what are your expectations? \_\_\_\_\_  
\_\_\_\_\_

How healthy do you want us to get your mouth?

**Don't really care**

**Average**

**The best it can be**

Should you need treatment, at which point should we address it?

**When my tooth hurts**

**When something is worsening**

**When something isn't ideal**

What quality of dentistry do you want us to recommend?

**Just patch it**

**Average**

**Ideal/ the best**

We have the ability to look at your mouth from 3 different perspectives.

What combination of these would you like us to use for you?

**As a general dentist**

**As a cosmetic dentist**

**As a functional dentist**

How do you feel about the appearance of your face and smile? \_\_\_\_\_  
\_\_\_\_\_

What would it take for you to trust us to be your dentist? \_\_\_\_\_  
\_\_\_\_\_

Tell us about your **good** experiences..... \_\_\_\_\_

And the bad ones \_\_\_\_\_

Has fear ever been an issue for you in a dental office? \_\_\_\_\_

What caused you to leave your last dental office? \_\_\_\_\_

Has time been a factor in getting your dental work done? \_\_\_\_\_

Has the cost of dental treatment been a concern for you? \_\_\_\_\_

What can we do to help you with this? \_\_\_\_\_

Name of previous Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

