



Dental/Medical Health History & Smile Assessment

First Name: _____ Last Name: _____

Reason for today's visit: _____

Date of last dental visit: ___/___/___ Date of dental x-rays: ___/___/___ Date of last cleaning: ___/___/___

Former Dentist: _____

Reason for changing dentists: _____

Have you had any problems with past dental treatment? _____

Are you nervous about seeing a dentist? Y / N If yes, please tell us why: _____

How many times a day do you brush your teeth? _____ How often do you floss? _____

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone: _____

Please check an answer for each of the following items

- | | |
|---|--|
| <input type="checkbox"/> <input type="checkbox"/> I clench or grind my teeth | <input type="checkbox"/> <input type="checkbox"/> My gums feel tender or swollen |
| <input type="checkbox"/> <input type="checkbox"/> My gums bleed while brushing or flossing | <input type="checkbox"/> <input type="checkbox"/> I have loose teeth or broken fillings |
| <input type="checkbox"/> <input type="checkbox"/> Food collects between my teeth | <input type="checkbox"/> <input type="checkbox"/> I have a tooth/teeth sensitive to cold |
| <input type="checkbox"/> <input type="checkbox"/> I avoid brushing part of my mouth due to pain | <input type="checkbox"/> <input type="checkbox"/> I have a tooth/teeth sensitive to heat |
| <input type="checkbox"/> <input type="checkbox"/> I have been told I have bad breath | <input type="checkbox"/> <input type="checkbox"/> I have a tooth/teeth sensitive when biting |
| <input type="checkbox"/> <input type="checkbox"/> I have clicking or popping in my jaw | <input type="checkbox"/> <input type="checkbox"/> I have sores or growths in my mouth |

We ask the following questions because health problems you may have or medications you may be taking could have an interrelationship with the dentistry you receive or need to receive.

- Y N
- I am under a physician's care now?
- I have been hospitalized or had a major surgery?
 If yes, type of operation _____ Year of operation _____
 If yes, type of operation _____ Year of operation _____
- I have had a serious neck or head injury?
- I take or have taken Phen-Fen or Redux?
- I take or have taken a bisphosphonate (e.g., Actonel, Fosamax, Forteo)
- I smoke or use tobacco? If yes, how much per day? _____ How many years? _____
- I have an artificial joint or implant? Knee Hip Other:
 Year of replacement or placement of implant: _____

Women

- Are you taking birth control medications?
- Are you, could you be or are you trying to become pregnant?

Are you allergic to any of the following?

- | | |
|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Aspirin | <input type="checkbox"/> <input type="checkbox"/> Latex |
| <input type="checkbox"/> <input type="checkbox"/> Ibuprofen (Motrin/Advil) | <input type="checkbox"/> <input type="checkbox"/> Metal |
| <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs/sulfites/sulfides | <input type="checkbox"/> <input type="checkbox"/> Acrylic |
| <input type="checkbox"/> <input type="checkbox"/> Penicillin/Amoxicillin | <input type="checkbox"/> <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> <input type="checkbox"/> Codeine/hydrocodone | <input type="checkbox"/> <input type="checkbox"/> Other medications – Which ones? _____ |

Do you have or have you had any of the following? (Please circle an answer for each one.) If you have ever had any serious illness not listed below please indicate the condition in the column next to Other.

<input type="checkbox"/> <input type="checkbox"/>	Heart disease	<input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/>	Hearing loss
<input type="checkbox"/> <input type="checkbox"/>	Heart murmur/Mitral valve prolapse	<input type="checkbox"/> <input type="checkbox"/>	Excessive urination and/or thirst	<input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted / Venereal disease
<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/> <input type="checkbox"/>	Fainting spells
<input type="checkbox"/> <input type="checkbox"/>	Abnormal blood pressure	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Glaucoma
<input type="checkbox"/> <input type="checkbox"/>	Congenital heart lesions	<input type="checkbox"/> <input type="checkbox"/>	Mononucleosis (Mono)	<input type="checkbox"/> <input type="checkbox"/>	Emotional disorder
<input type="checkbox"/> <input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/> <input type="checkbox"/>	Herpes	<input type="checkbox"/> <input type="checkbox"/>	Nervous disorder
<input type="checkbox"/> <input type="checkbox"/>	Anemia	<input type="checkbox"/> <input type="checkbox"/>	Arthritis	<input type="checkbox"/> <input type="checkbox"/>	Liver disease
<input type="checkbox"/> <input type="checkbox"/>	Prolonged bleeding disorder	<input type="checkbox"/> <input type="checkbox"/>	Kidney disease	<input type="checkbox"/> <input type="checkbox"/>	Anaphylactic reaction
<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis or Lung disease	<input type="checkbox"/> <input type="checkbox"/>	Tumor or Malignancy	<input type="checkbox"/> <input type="checkbox"/>	Hemophilia
<input type="checkbox"/> <input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/>	Cancer/Chemotherapy	<input type="checkbox"/> <input type="checkbox"/>	Lung disease
<input type="checkbox"/> <input type="checkbox"/>	Hay fever	<input type="checkbox"/> <input type="checkbox"/>	Radiation treatment	Other	
<input type="checkbox"/> <input type="checkbox"/>	Sinus trouble	<input type="checkbox"/> <input type="checkbox"/>	History of drug addiction	Other	
<input type="checkbox"/> <input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/> <input type="checkbox"/>	History of alcohol abuse	Other	
<input type="checkbox"/> <input type="checkbox"/>	Ulcers	<input type="checkbox"/> <input type="checkbox"/>	HIV/AIDS	Other	
<input type="checkbox"/> <input type="checkbox"/>	Liver disease	<input type="checkbox"/> <input type="checkbox"/>	Suppressed immune system	Other	

Please List all medications you are currently taking (please list prescription and over-the-counter medications)

Medicine _____ Taking it for: _____

Medicine _____ Taking it for: _____

Medicine _____ Taking it for: _____

Medicine _____ Taking it for: _____

Medicine _____ Taking it for: _____

Medicine _____ Taking it for: _____

Physician's Name: _____ Clinic Name: _____

Phone Number: _____ City & State: _____

Medical History Review/Update:

Signature	Date	Signature	Date

Smile Assessment

Do you like your smile? If no, what would you change? _____

Are you missing any teeth? If so, how long have they been missing? _____

Are you currently wearing any partials or dentures? If so, how old are they? _____

Are they giving you any trouble? _____

Do you have any crowns or bridges? If so, how old are they? _____

Are they giving you any trouble? _____

If you could change one thing about your smile, what would it be? _____

Notes: