

Dental History

Reason for today's visit: _____

When was your last dental visit: _____

How often do you brush your teeth: _____ What texture toothbrush do you use: Soft Medium Hard

Is there anything about your smile that you do not like: _____

What would you like to accomplish in your dental treatment: _____

**Please circle an answer for each question listed below:*

Do you have any old fillings or treatment that you are unhappy with:	YES	NO	Would you like your teeth to be whiter:	YES	NO
Do your gums bleed while brushing:	YES	NO	Do you have frequent headaches:	YES	NO
Do your gums bleed when flossing:	YES	NO	Do you clench or grind your teeth:	YES	NO
Are your teeth sensitive to hot, cold, sweet or sour foods or liquids:	YES	NO	Do you bite your lips or cheeks frequently:	YES	NO
Have you noticed any loosening of your teeth:	YES	NO	Have you ever had:		
Does food tend to become caught between your teeth:	YES	NO	Orthodontic treatment (Braces):	YES	NO
Do you have any sores or lumps in or near your mouth:	YES	NO	Oral Surgery:	YES	NO
Have you ever experienced any of the following problems in your jaw:			Your teeth reshaped or bite adjusted:	YES	NO
Clicking	YES	NO	Worn a night guard, bite plate or other appliance:	YES	NO
Pain (joint, ear, side of face)	YES	NO	Are you satisfied with the appearance of your teeth and smile:	YES	NO
Difficulty opening/closing	YES	NO	Have you ever had an upsetting experience in a dental office:	YES	NO
			Is there anything about having dental treatment done that concerns you: _____	YES	NO

Medical History

Do you consider yourself to be in good health:	YES	NO	Have you had any abnormal bleeding:	YES	NO
Have there been any changes in your general health within the past year: _____	YES	NO	Do you bruise easily:	YES	NO
When was your last physical exam: _____			Have you ever required a blood transfusion:	YES	NO
Physician's name: _____			Do you use tobacco:	YES	NO
Address: _____			Do you use alcohol:	YES	NO
Telephone: _____			Do you use cocaine or other drugs:	YES	NO
Are you currently under the care of a physician:	YES	NO	Are you wearing contact lenses:	YES	NO
Have you ever been hospitalized for any surgical operation or serious illness:	YES	NO	Do you have any disease, condition, or problem not listed above that you believe I should know about:	YES	NO
If yes, please explain: _____			If yes, please explain: _____		
Are you currently taking any medication(s) including nonprescription medicine(s):	YES	NO	Are you allergic to or have you had reactions to:		
If yes, list here: _____			Local anesthetics:	YES	NO
Have you had recent weight loss:	YES	NO	Penicillin:	YES	NO
Are you currently taking diet pills or herbs:	YES	NO	Sulfa Drugs:	YES	NO
If yes, list here: _____			Barbiturates, Sedatives or Sleeping Pills:	YES	NO
Have you or are you currently taking osteoporosis medication such as Fosamax®:	YES	NO	Aspirin:	YES	NO
If yes, list here: _____			Iodine:	YES	NO
			Latex:	YES	NO
			Other Antibiotics: _____		
			Other Allergies: _____		