DENTAL HISTORY UPDATE

Patients Name:______________________

Please check any of the following problems that apply to you.	**Yes**	**No**
-Sensitivity (hot, cold, sweet)	☐	☐
-Tooth pain or discomfort when chewing	☐	☐
-Headaches, earaches, neck pain	☐	☐
-Jaw joint pain	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath or bad taste in your mouth	☐	☐

	Yes	**No**
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco? How much? For how long?	☐	☐
If I could change my smile, I would:	☐	☐
-Make them brighter	☐	☐
-Make them straighter	☐	☐
-Close spaces	☐	☐
-Replace black metal fillings with natural, tooth-colored fillings	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐

On a scale of 1 – 10, with 10 being the highest rating:

-How Important is Your Dental Health to You?

1 2 3 4 5 6 7 8 9 10

- Where Would You Rate Your Current Dental Health??

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?

____

What is the most important thing to you about your future smile and dental health?

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Notes:

MEDICAL HISTORY UPDATE

Please check any of the following that apply to you:

- ☐ AIDS
- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer -Type ___________
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaw Joint Pain
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Pregnant Currently
  - # of wks?_________
- ☐ Breast Feeding
- ☐ On Birth Control
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Long Term Steroid Use
- ☐ Smoker
  - # pks/ day __________
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers

Do you have any of the following drug allergies?

- ☐ Aspirin
- ☐ Sulfa
- ☐ Codeine
- ☐ Penicillin
- ☐ Clindamycin
- ☐ Other

Are you under a physician's care currently?
Please Explain:

____

Are you taking any <u>medications</u>? Names?

Please list <u>past surgeries</u> and dates or any other medical or dental information we should know about -

Patient Signature (Parent of Child) **Date** **Dentist Signature** **Date**

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