

Dental Health History

Patient's Name _____ Birth Date _____ Today's Date _____

Please circle the correct response (Yes or No); answer all questions. If you are not sure, just go to the next question. The following questions are for our records only and will be considered confidential information.

Dental History

Why are you seeing the dentist today? _____

- 1. Have you ever had any problems after dental extractions or treatment?..... Yes No
- 2. Have you ever had a bad or unusual reaction to a local or general dental anesthetic? Yes No
- 3. Have you ever had an injury to your face, teeth, jaws? Yes No
- 4. Have you ever had surgery in/on your mouth or lips? Yes No
- 5. Have you ever had radiation treatment of your neck or head? Yes No
- 6. Have you ever had any teeth pulled? Yes No
- 7. Do you have bleeding gums? Yes No
- 8. Do you ever have sores in your mouth? Yes No
- 9. Do you have trouble chewing?..... Yes No
- 10. Do you clench or grind your teeth? Yes No
- 11. Do you have trouble opening your mouth as wide as you would like? Yes No
- 12. Do your jaw joints, jaw muscles or neck hurt often?..... Yes No
- 13. Does your jaw ever lock, click or pop? Yes No
- 14. Are you wearing any removable dental appliances? Yes No

If Yes, for how many years? _____

For how many years have you been without your permanent teeth? _____

If you have dentures and you are not wearing them, for how long have you not been wearing them? _____

Medical History

- 1. Are you in good health? Yes No
- 2. Have there been changes in your general health in the past year? Yes No

Do you have or have you had any of the following:

- 3. Heart problems such as heart attack, chest pain, irregular heart beat, artificial heart valve, previous endocarditis, damaged (scarred) heart valves, congenital heart defects, heart transplant? Yes No
- 4. Pacemaker, defibrillator or other cardiac device? Yes No
- 5. Shortness of breath or chest pain with mild exercise? Yes No
- 6. High or low blood pressure? Yes No
- 7. Stroke or mini-stroke (TIA)? Yes No
- 8. Blood disorders such as anemia, hemophilia, clotting disorder? Yes No
- 9. Lung problems such as tuberculosis, emphysema, bronchitis, COPD? Yes No
- 10. Sinus trouble, hay fever, asthma? Yes No
- 11. Any reactions to drugs or other types of allergies? Yes No

If Yes, please list _____

- 12. History of biophosphonate medications (intravenous - - Zometa, Aredia, Reclast, or Bonefos, or oral medications - - Actonel, Boniva, Fosamax, Fosamax Plus D, Skelid or Didronel?) Yes No
- 13. Allergy to latex or rubber products? Yes No
- 14. Hives or skin rash? Yes No
- 15. Any STDs (syphilis, gonorrhea, herpes or other)? Yes No
- 16. AIDS or other immunosuppressive disorder or positive HIV test? Yes No
- 17. Hepatitis, jaundice or liver disease? Yes No
- 18. Diabetes (high blood sugar) or low blood sugar? Yes No
- 19. Kidney disease or dialysis? Yes No
- 20. Ulcers, stomach or intestinal problems? Yes No
- 21. Fainting spells, convulsions, seizures or epilepsy? Yes No

