THE DENTAL PRACTICE

MEDICAL AND DENTAL HISTORY

Name _____ Physician's Name _____
Date of last medical physical _____ Date of last dental visit _____

How did you hear about us? _____

PLEASE CIRCLE YOUR ANSWER

On a scale of 1-10 (10: unbearable), please rank the pain you are experiencing today:
1 2 3 4 5 6 7 8 9 10
On a scale of 1-10 (10: excellent), please rate your oral health today:
1 2 3 4 5 6 7 8 9 10
On a scale of 1-10 (10: very important), please rate the importance of oral health to you:
1 2 3 4 5 6 7 8 9 10

How often do you brush your teeth? _____How often do you floss? _____

Are you unhappy with how your teeth look?	YES	NO
Have you had problems with previous dental treatment?	YES	NO
Explain: _____		
Have you ever been hospitalized or had a major operation?	YES	NO
Explain:_____		
Have you had a serious head or neck injury/trauma?	YES	NO
Explain: _____		
Do you take blood thinners or bruise easily?	YES	NO
Have you ever had MRSA or an infection that did not respond to antibiotics?	YES	NO
Have you taken Foxamax, Boniva, Actonel, Denosumab or any other medication for bone health/osteoporosis?	YES	NO
Have you had joint replacement surgery?	YES	NO
Have you been told you need antibiotics before dental treatment?	YES	NO
Have you had braces?	YES	NO
Do you use tobacco?	YES	NO
Do you have a history of drug or alcohol abuse?	YES	NO
Do you use controlled substances?	YES	NO
Do you have issues opening/closing your mouth fully? Chewing gum or nuts?	YES	NO
Do you experience dry mouth?	YES	NO

Women:

Are you pregnant or trying to get pregnant?	YES	NO
* Due date: ___/_____		
Are you taking contraceptives (Birth Control) or other hormones?	YES	NO
Are you nursing?	YES	NO

Are you currently taking any medications? YES NO

- If yes, please write them here or provide a list to your dentist today

Are you allergic to anything? (foods, latex, metals, medicines): YES NO

- If yes, please write them here or provide a list to your dentist today

Do you have, or have you EVER had, any of the following?

HEAD/ NEUROLOGIC

Epilepsy or Seizures?	YES	NO
Thyroid disease?	YES	NO
Stroke?	YES	NO
Glaucoma?	YES	NO
Alzheimer's Disease / Dementia?	YES	NO
Frequent headaches?	YES	NO
Depression, anxiety, bipolar?	YES	NO
Psychiatric care?	YES	NO

HEART/BLOOD

Heart attack/failure?	YES	NO
Heart murmur?	YES	NO
Heart Pacemaker?	YES	NO
Artificial Heart Valve?	YES	NO
Blood disorder/bleeding disorder?	YES	NO
High blood pressure?	YES	NO
High Cholesterol?	YES	NO
Mitral Valve Prolapse?	YES	NO
Chest Pain?	YES	NO

LUNGS

Asthma?	YES	NO
Emphysema/COPD?	YES	NO
Tuberculosis?	YES	NO
Hay fever/seasonal allergies?	YES	NO

URINARY/METABOLIC

Kidney problems?	YES	NO
Urinary Tract Infections?	YES	NO
Excessive thirst?	YES	NO
Diabetes?	YES	NO

LIVER

AIDS/HIV?	YES	NO
Hepatitis A, B or C?	YES	NO
Herpes (cold sores/fever blister)?	YES	NO
Blood transfusion?	YES	NO

STOMACH/DIGESTION

Acid reflux (heartburn) or ulcers?	YES	NO
Difficulty chewing or swallowing?	YES	NO
Do you gag easily?	YES	NO
Are you on a special diet?	YES	NO

*Explain: _____

BONE/ OTHER

Arthritis?	YES	NO
Osteoporosis?	YES	NO
Pain in jaw joints?	YES	NO
Tumors or growths?	YES	NO
Cancer?	YES	NO

*Diagnosis: _____

Chemotherapy?	YES	NO
Radiation?	YES	NO
Scarlet Fever?	YES	NO
Had the HPV vaccination?	YES	NO
Autoimmune disease?	YES	NO
Other chronic disorder/disease?	YES	NO

Explain: _____

TMJ (The Jaw Joint) HEALTH

Have you been diagnosed with TMJ or TMD?	YES NO
Do you clench or grind your jaws frequently?	YES NO
Does your jaw make noise that bothers you or others?	YES NO
Does jaw or muscle pain affect you daily?	YES NO
Do you have any tension or cluster headaches?	YES NO
Do you get migraine headaches?	YES NO

SLEEP AND AIRWAY

Do you snore?	YES NO
Have you been diagnosed with sleep apnea or a sleep disturbance?	YES NO
Do you use a CPAP or other device?	YES NO
Do you experience daytime sleepiness or fatigue?	YES NO
Do you primarily breathe through your mouth or nose?	MOUTH NOSE
Can you breath fully through your nose?	YES NO

The team at The Dental Practice takes a whole-body approach to your oral care. Please ask your provider for more information on how the health of the mouth affects the rest of your body.

Patient signature: _____ Date: _____
If patient is under 18: Parent or Legal Guardian Signature:_____