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

- ☐ ☐ I clench or grind my teeth
- ☐ ☐ My gums bleed while brushing or flossing
- ☐ ☐ Food collects between my teeth
- ☐ ☐ I avoid brushing part of my mouth due to pain
- ☐ ☐ I have been told I have bad breath
- ☐ ☐ I have clicking or popping in my jaw
- ☐ ☐ My gums feel tender or swollen
- ☐ ☐ I have loose teeth or broken fillings
- ☐ ☐ I have a tooth/teeth sensitive to cold
- ☐ ☐ I have a tooth/teeth sensitive to heat
- ☐ ☐ I have a tooth/teeth sensitive when biting
- ☐ ☐ 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?

- ☐ ☐ Aspirin
- ☐ ☐ Ibuprofen (Motrin/Advil)
- ☐ ☐ Sulfa drugs/sulfites/sulfides
- ☐ ☐ Penicillin/Amoxicillin
- ☐ ☐ Codeine/hydrocodone
- ☐ ☐ Latex
- ☐ ☐ Metal
- ☐ ☐ Acrylic
- ☐ ☐ Local Anesthetics
- ☐ ☐ Other medications – Which ones? ______________________

____

- OVER -

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.

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