## **MEDICAL HISTORY**

Patient Name				Nickname Age								
Name of Physician/and their specialty												
Most recent physical examination			_ Pu	rpose _								
What is your estimate of your general health?			celler	-	Good				Poor			
DO YOU HAVE or HAVE YOU EVER HAD:	YES	NC	_								YES	NO
	_										113	
1. hospitalization for illness or injury 2. an allergic or bad reaction to any of the following:  O aspirin, ibuprofen, acetaminophen, codeine O penicillin O erythromycin O tetracycline O sulfa O local anesthetic O fluoride O chlorhexidine (CHX) O lodine O metals (nickel, gold, silver, O nuts O fruit O milk O red dye O other  3. heart problems, or cardiac stent within the last six months 4. history of infective endocarditis 5. artificial heart valve, repaired heart defect (PFO) 6. pacemaker or implantable defibrillator 7. orthopedic or soft tissue implant (e.g. joint replacement, breast implant) 8. heart murmur, rheumatic or scarlet fever 9. high or low blood pressure 10. a stroke (taking blood thinners) 11. anemia or other blood disorder 12. prolonged bleeding due to a slight cut (or INR > 3.5)			27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46.	medicatic arthritis of autoimm (e.g. rheu glaucom contact le head or repilepsy, neurolog viral infection any lump hives, ski STI/STD/ hepatitis HIV/AIDS tumor, al radiation chemothemothemothemothon psychiatr concentral cohol/rest YOU:	eoporosis/osteopenia or ever taken anti-resorptive edications (e.g. bisphosphonates)				n disease)_			
<ol> <li>pneumonia, emphysema, shortness of breath, sarcoidosis</li></ol>			48. 49. 50. 51. 52.	aware of (e.g., feve taking m taking di often exh experien	a change r, chills, nevel edication t etary suppo nausted or cing frequ	in your w cough, for weig plement r fatigue uent hea	health in , or diarright man es, vitamed adaches	n the la hea) ageme ins, and or chro	st 24 hours  nt l/or probiotics  nic pain smokeless tobac			
<ol> <li>hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome)</li></ol>	_		54. 55. 56. 57. 58. evelop	vaping, e-c consider often un taking bi currently diagnose	eigarettes, ar ed a touch happy or c orth control pregnant ed with a p	nd cannal ny/sensi depressa I pills _ crostate	bis) tive pers ed disorde	son _	at may possi	ibly affe	ct you	
dental treatment. (i.e. Botox, Collagen Injections)												
List all medications, supplements, vi	itamins	, and	d/or p	robiotics	taken v	vithin t	the las	t two	years.			
Drug Purpose												
PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE I Patient's Signature  Doctor's Signature								Dat	e			
-												

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DENIAL HISTORY									
Pati	ent Name Nic	ckname	Age						
Refe	erred by Ho	w would you rate the condition of your mouth? Excellent	]Good □	Fair 🗌	Poor				
Previous Dentist How long have you been a patient? Months/\(\text{Months}\)									
Date of most recent dental exam/ Date of most recent x-rays//									
	e of most recent treatment (other than a cleaning)								
l rou	utinely see my dentist every 3 mo. 4 mo. (	☐ 6 mo. ☐ 12 mo. ☐ Not routinely							
	AT IS YOUR IMMEDIATE CONCERN?								
PLE	ASE ANSWER YES OR NO TO THE FOLLOWIR	NG:							
PER	SONAL HISTORY	0	00	YES	NO				
1.	Are you fearful of dental treatment? How fearful, on a scale	of 1 (least) to 10 (most) []							
· · · · · · · · · · · · · · · · · · ·									
<ul> <li>2. Have you had an unfavorable dental experience?</li> <li>3. Have you ever had complications from past dental treatment?</li> </ul>									
4.		s to local anesthetic?			$\Box$				
5. 6.		bite adjusted, and at what age?eveloped or lost teeth due to injury or facial trauma?eveloped							
				U	<u> </u>				
	M AND BONE		00	YES	NO				
7.	Do your gums bleed sometimes or are they ever painful whe			$\Box$	$\Box$				
8. 9.		root planing, or been told you have lost bone around your teeth? outh?							
9. 10.									
11.	<ul><li>10. Is there anyone with a history of periodontal disease in your family?</li></ul>								
12.		thout an injury), or do you have difficulty eating an apple?		Ō	Ō				
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?									
TOC	OTH STRUCTURE	•	00	YES	NO				
14.	Have you had any cavities within the past 3 years?								
15.		o you have difficulty swallowing any food?							
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?									
<ul><li>17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?</li><li>18. Do you have grooves or notches on your teeth near the gum line?</li></ul>									
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?									
<ul> <li>18. Do you have grooves or notches on your teeth near the gum line?</li> <li>19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?</li> <li>20. Do you frequently get food caught between any teeth?</li> </ul>									
BITE	E AND JAW JOINT		00	YES	NO				
21.		nited opening, locking, popping)		_					
22.		ou try to bite your back teeth together?		0000000000	$\tilde{\Box}$				
23.		agels, baguettes, protein bars, or other hard, dry foods?		Ō	Ō				
24.		r, thinner, or worn) or has your bite changed?			000000000				
25.	-	pped?							
26. 27.		p your teeth together, or shift your jaw to make your teeth fit together?							
28.		teeth against your tongue?		$\Box$	$\mathcal{C}$				
29.									
30.	0. Do you clench or grind your teeth together in the daytime or make them sore?								
31.	31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?								
32.	Do you wear or have you ever worn a bite appliance?								
SMI	LE CHARACTERISTICS	0	00	YES	NO				
33.		s, teeth, gums) that you would like to change (shape, color, size, display)?			$\bigcirc$				
34.									
<ul><li>35. Have you felt uncomfortable or self conscious about the appearance of your teeth?</li><li>36. Have you been disappointed with the appearance of previous dental work?</li></ul>									
				U					
Pati	ent's Signature	Da	te						
Doc	tor's Signature	Da	te						

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