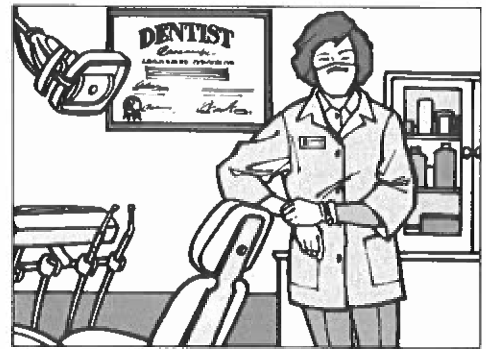
Giving Medical Histories

GOING TO A NEW DENTIST

Dentists usually collect basic information about all their patients. The receptionist at a dentist's office asks new patients to complete a dental questionnaire before their exam. This helps the dentist provide better care. Complete the "Dental History" form using your personal information.



DENTAL HISTORY

Patient Name ______________ Patient Account No. ______________ Medical Alert ______________

What is the reason for your visit today? ______________

Date of: **Last dental visit** ______________ **Last dental cleaning** ______________ **Last full-mouth X-rays** ______________

Do you have other dental problems? YES NO If yes, please describe: ______________

What procedures were performed at your last dental visit? ______________

Are any of your teeth sensitive to:

Hot or cold?	YES	NO
Sweets?	YES	NO
Biting or chewing?	YES	NO
Have you noticed any mouth odors or bad taste?	YES	NO
Do you frequently get cold sores, fever blisters, mouth ulcers, or other oral lesions?	YES	NO
Do your gums bleed or hurt?	YES	NO
Have you noticed any loose teeth or a change in your bite?	YES	NO
Does food tend to get caught between your teeth?	YES	NO

If yes, where? ______________

Have your parents experienced gum disease or tooth loss?	YES	NO

Do you:

Clench or grind your teeth while awake or asleep?	YES	NO
Bite your lips or cheeks regularly?	YES	NO
Crush ice with your teeth?	YES	NO
Breathe through your mouth while asleep or awake?	YES	NO
Have tired jaws, especially in the morning?	YES	NO
Smoke/chew tobacco?	YES	NO

Have you ever had:

Orthodontic treatment?	YES	NO
Oral surgery?	YES	NO
Periodontal treatment?	YES	NO
Teeth ground or bite adjusted?	YES	NO
A bite plate or mouth guard?	YES	NO
A serious injury to your mouth or head?	YES	NO

If so, please describe, including cause: ______________

Have you experienced:

Clicking or popping of the jaw?	YES	NO
Pain (joint, ear, side of face)?	YES	NO
Difficulty in opening or closing your mouth?	YES	NO
Difficulty in chewing on either side of your mouth?	YES	NO
Headaches, neck aches, or shoulder aches?	YES	NO
Sore muscles (neck, shoulders)?	YES	NO

Are you satisfied with your teeth's appearance?

Do you want to keep all of your teeth for life?	YES	NO
Do you feel nervous about having dental treatment?	YES	NO
Have you ever had an upsetting dental experience?	YES	NO

If yes, please describe: ______________

Have you been under the care of a medical doctor during the past two years? YES NO If yes, please describe: ______________

Do you have high blood pressure? YES NO If yes, what is your normal blood pressure?: ______________

Are you aware of having an allergic or adverse reaction to any medication or substance? YES NO If yes,describe: ______________

I understand the above information is necessary for proper dental care. I have answered all questions to the best of my knowledge. I will notify the dentist of any change in my health or medication.

Patient Signature ______________ Date ______________