Patient's Dental History

Family Dentist ____________________________________

Date of most recent dental exam ____________________

Is this visit for a second opinion? Y N

What are the reasons for consulting with our office today?

____

____

Whom may we thank for referring you to our office?

____

Was there anyone else who influenced your decision to call our office? ____________________________

Any family members who have had orthodontics?

____

Is there anything else you would like us to know in order to serve you well? ______________________

Has patient ever had, or now have any of the following:

- ________ Any clicking, popping or pain of the jaw or jaw joints (TMJ)
- ________ Any missing teeth or extra teeth
- ________ Bites lips or cheeks frequently
- ________ Bleeding gums, bad taste in mouth
- ________ Clenching/grinding habit
- ________ Difficulty chewing
- ________ Difficulty closing or opening jaws
- ________ Injuries to your face, jaw, mouth or teeth
- ________ Previous/present orthodontic treatment
- ________ Prolonged bleeding following extractions
- ________ Root canals, crowns, or bridges
- ________ Teeth sensitive to hot/cold
- ________ Thumbsucking/finger habit

Patient's Medical History

Has patient been under the care of a physician in the last two years? ____________________________

Does patient need to be pre-medicated? Y N

Does patient use tobacco? Y N

List of medications/supplements patient currently takes:

____

____

____

Patient's Medical History continued

Has patient ever had, or now have any of the following:

- ________ Adenoids/tonsils removed
- ________ Aids or HIV
- ________ Anemia
- ________ Arthritis
- ________ Asthma/Respiratory Disease
- ________ Cancer
- ________ Chronic neck pain
- ________ Diabetes
- ________ Ear pain
- ________ Endocrine problems
- ________ Epilepsy
- ________ Fainting or dizziness
- ________ Frequent headaches
- ________ Heart disease
- ________ Hepatitis
- ________ High blood pressure
- ________ Joint replacement or implants
- ________ Learning disabilities
- ________ Liver/kidney disease
- ________ Sinus trouble
- ________ Speech problem
- ________ Tuberculosis

Is patient allergic to, or has patient reacted adversely to:

- ________ Aspirin
- ________ Barbiturates, sedatives or sleeping pills
- ________ Codeine or other narcotics
- ________ Ibuprofen
- ________ Latex allergy
- ________ Local anesthetics
- ________ Penicillin or other antibiotics
- ________ Sulfa drugs
- ________ Other allergies ______________________________

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