DENTAL HISTORY UPDATE

Patients Name: _____

Please check any of the following problems that apply to you.	**Yes**	**No**
-Sensitivity (hot, cold, sweet)		
-Tooth pain or discomfort when chewing	☐	☐
-Headaches, earaches, neck pain	☐	☐
-Jaw joint pain	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath or bad taste in your mouth	☐	☐
- Snoring	☐	☐

On a scale of 1 – 10, with 10 being the highest rating:

-Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?

Do you smoke or use chewing tobacco or Vape? How much? For how long?	**Yes** ☐	**No** ☐
If I could change my smile, I would:		
-Make them brighter	☐	☐
-Make them straighter	☐	☐
-Close spaces	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Replace black metal fillings with natural tooth-colored fillings	☐	☐
- If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐

- How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

MEDICAL HISTORY UPDATE

Please check any of the following that apply to you:

Y N	**Y N**	**Y N**	**Y N**
☐ ☐ Allergies (Seasonal)	☐ ☐ Emphysema	☐ ☐ Osteoporosis	☐ ☐ Ulcers
☐ ☐ Anemia	☐ ☐ Fainting	☐ ☐ Jaundice	☐ ☐ Other:
☐ ☐ Arthritis	☐ ☐ Glaucoma	☐ ☐ Jaw Joint Pain	
☐ ☐ Artificial Joints	☐ ☐ Head Injuries	☐ ☐ Pacemaker	**For WOMEN Only**
☐ ☐ Artificial Heart Valve	☐ ☐ Heart Disease	☐ ☐ Pre-Medication	☐ ☐ Birth Control Pills
☐ ☐ Asthma	☐ ☐ Heart Conditions	☐ ☐ Radiation (head/neck)	☐ ☐ Breast-feeding
☐ ☐ Back Problems	☐ ☐ Heart Murmur	☐ ☐ Respiratory Problems	☐ ☐ Pregnant
☐ ☐ Cancer	☐ ☐ other Heart conditions	☐ ☐ Seizures	☐ ☐1-3 mos,3-6 mos,6-9mos,
☐ ☐ Chemotherapy	☐ ☐ Hepatitis A B C	☐ ☐ Stomach Problems	
☐ ☐ Circulatory Problems	☐ ☐ High Blood Pressure	☐ ☐ Stroke	
☐ ☐ Diabetes	☐ ☐ Low Blood Pressure	☐ ☐ Swelling – Feet/Ankles	
☐ ☐ Dizziness	☐ ☐ Kidney Disease	☐ ☐ Thyroid Disease	
☐ ☐ Excessive Bleeding	☐ ☐ Liver Disease	☐ ☐ Tuberculosis	

Do you have any of the following drug allergies?

☐ ☐ Aspirin	☐ ☐ Penicillin
☐ ☐ Codeine	☐ ☐ Sulfa
☐ ☐ Erythromycin	☐ ☐ Tetracycline
☐ ☐ Ibuprofen	☐ ☐ Tylenol
☐ ☐ Latex	☐ ☐ Other

Are you under a physician's care? What for?

_____

Are you taking any medications? What?

_____

_____

_____

Is there any other medical or dental information we should know about? _____

_____

Patient Signature
(Parent of Child) **Date** **Dentist Signature** **Date**