Mark all that apply: Dental Health

	Yes		Yes
Mouth odors/bad taste		Dry mouth / excessive	
History of Perio Treatment / Root Planing		Treatment for tempormandibular disorder (TMJ or TMD) Clenching /grinding/popping/clicking/pain	
Sensitive teeth? Hot, cold, pressure or sweets		Cold sores/blisters/oral lesions/ Aphtous ulcers Herpes	
Are you aware of any lumps or swellings		How many soft drinks do you drink a day	
Sore bleeding gums		Family history of extensive decay	
One or more filling in the last 3 years		Have you had oral surgery, Wisdom or other teeth extracted?	
Have you had orthodontics (braces)?		Do you wear a denture or partial denture	
Flossing _____X Daily		Have you had any dental implants placed	
Brushing _____X Daily Electric_____ Manual_____		Snore / Sleep Apnea	
Primary sources of drinking water: **Please circle:** City Water ☐ At home Filtration ☐ Well Water ☐ Bottled Water ☐		**Fluoride:** Water: _____ Toothpaste:_____ **Prescription** Fluoride:_____ Paste:_____ Rinse:_____	

Please circle:

Yes No Do you dislike the color of your teeth?
Yes No Do you have spaces between your teeth that bother you?
Yes No Do you have chips or uneven edges on your teeth?
Yes No Do you feel that your teeth are too long or too short?
Yes No Do you have dark fillings that show when you smile?
Yes No Do you feel your teeth are crowded or crooked?
Yes No Do you have existing crowns or dental work you consider ugly?
Yes No Are you self-conscious of your teeth and /or smile?
Yes No Would you like to improve your existing smile?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature Date

Medical Dental History Form

Name:_____

Name of Drug	Strength MG	Frequency Taken	Medication Taken for?
Have you ever taken medication containing bisphosphonates?	**Yes**	**No**	**Example: Fosamax, Boniva, Actonel (Osteoporosis Medications)**

Allergies to Medications	
Name of the Drug	Reaction you had

Latex Allergy _____ Yes _____ No

Past and Current Medical Conditions: Circle all that apply

Under Physicians' care	Heart trouble	Rheumatic Fever
Hospitalization? Operations in last 5 years Details:	Heart Surgery: Explain	High Blood Pressure
	Stroke	
	Artificial Heart Valves	Artificial Joint
Women Pregnant Due Date: _____	Anemia	Pre-medication needed prior to dental treatment
Diabetes: Type Controlled by:	Tobacco Use: Smoke / Chew/ Vape/JUUL If quit, What Year: _____	Lung disease
		Leukemia
Emphysema/ COPD	Shortness of Breath	Sleep Apnea C-Pap
Sinus Trouble	Kidney Disease	Cancer Type:_____ Date: _____
Dialysis	Chemotherapy Date:_____	Eating Disorder
Radiation Treatment to Head/Neck	Autoimmune disease: Lupus, Pemphigus, Multiple Sclerosis, Other	Asthma Inhaler?
Stomach Trouble Reflux, Ulcer, GERD	Head/neck/mouth Injuries	Glaucoma
Arthritis or joint disorder	Headaches	Neurologic disease
Fainting / Dizziness	AIDS/HIV Positive	Thyroid Disorder
Depression/Anxiety	Other psychiatric disorders	Convulsions/ Epilepsy/ seizures
Cerebral palsy	Alcohol or chemical dependency	Blood Thinners