DENTAL HEALTH HISTORY

Name: _____

Do you presently have any pain or concerns with your mouth? Please describe:

_____

_____

Please mark the ☐ if you have the following:

☐ Do you clench or grind your teeth? ☐ Have you ever injured your face or jaw?

☐ Has your jaw ever locked opened? ☐ Do you have difficulty opening your mouth wide?

☐ Does your jaw tire when you chew? ☐ Does your jaw click or pop?

☐ Are your jaw and temple muscles tender when you press on them?

☐ Do you snore? ☐ Do you wake up tired? ☐ Do you feel the need to take naps?

☐ Do any teeth feel loose?

☐ Do you have any food traps (food impaction between teeth)?

☐ Do your gums bleed when you brush?

☐ Have your gums ever been treated?

☐ Do you presently have mouth ulcers?

☐ Are you allergic to latex?

Are any of your teeth sensitive to? ☐ Heat ☐ Cold ☐ Biting Pressure ☐ Sweets

MEDICAL HEALTH HISTORY

Do you have any general health problems? Please describe:

_____

Are you currently being treated by a physician for a medical condition? Please describe:

_____

Physician _____ Phone _____

Have you been hospitalized within the past two years? _____

Do you smoke or use oral tobacco products? Please describe: _____

PLEASE TURN OVER →

For women: Are you pregnant or is there a possibility that you may be pregnant? _____

Are you allergic to any drugs or medications? _____

Are you currently taking any drugs or medications? If yes, please list: _____

_____

_____

Do you have a history of chemical dependency (drug or alcohol)? If so, how long have you been in recovery?

_____

_____

*** Please note the use of recreational drugs can interact adversely with our use of Xylocaine (Novocain) ***

Please mark the ☐ if you have the following:

☐ High blood pressure	☐ Respiratory Disease	☐ Blood disorders
☐ Hepatitis	☐ Diabetes	☐ Night sweats/fever
☐ Asthma	☐ Tuberculosis	☐ Heart attack/angina
☐ Epilepsy	☐ Kidney Disease	☐ Tumors or Cancer
☐ Liver Disease	☐ Endocrine Disease	☐ Unusual weight Loss

☐ Acquired Immunodeficiency Disease/Other Venereal Disease

**** IF <u>CHANGED</u>, UPDATE THE FOLLOWING INFORMATION: ****

Home Telephone Number: _____

Cellphone Number (to receive appointment reminders): _____

Email Address: _____

Home Address: _____

_____

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT AND VALID

Signature _____ Date _____