Dental History

Name: _____ **Date:**__ __ __/_____/_____

Reason for Visit: _____

What is the reason for your dental visit today? **EXAMINATION EMERGENCY CONSULTATION PROCEDURE**

Specify: _____

PAST DENTAL TREATMENT:

YES NO DK Have you been to the dentist before?

If yes, how long ago was your last dental exam? 0-6 months 6-12 months 1-2 years >2 years

If yes, how long ago was your last dental x-rays? 0-6 months 6-12 months 1-2 years >2 years

If yes, how long ago was your last dental cleaning? 0-6 months 6-12 months 1-2 years >2 years

YES NO DK Do you have a history of tooth extraction or oral surgery?

(Specify): **EXTRACTIONS IMPLANTS JAW SURGERY TMJ SURGERY TRAUMA**

YES NO DK Have you had any periodontal (gum) treatments? (Specify): **DEEP CLEANING SURGERY**

YES NO DK Do you have any bridges or wear dentures or partials? (Specify): **BRIDGES DENTURES PARTIALS**

YES NO DK Have you ever had root canal treatment?

YES NO DK Have you ever had orthodontic (braces) treatment?

YES NO DK Have you had a local anesthetic (Lidocaine) for dental purposes?

YES NO DK Have you had any problems associated with previous dental treatment?

YES NO DK Has fear ever prevented you from seeking dental care?

DENTAL PROBLEMS (SIGNS/SYMPTOMS): _____

YES NO DK Are you currently experiencing dental pain or discomfort?

If yes, is it causing headaches, earaches or neck pain? (Specify): **Headaches Earaches Neck pains**

YES NO DK Are your teeth sensitive to cold, hot, sweets or pressure? (Specify): **Cold Hot Sweets Pressure**

YES NO DK Do you have problems with eating? (Specify): **Trouble Chewing Swallowing Vomiting Other**

YES NO DK Do you have swelling in or around your mouth, face or neck? (Specify): **Mouth Face Neck**

YES NO DK Do you have loose teeth?

YES NO DK Do you have any clicking, popping, discomfort, or limited opening in the jaw?

DENTAL DISEASE PREVENTION (ORAL HYGIENE): _____

How often and when do you brush your teeth? **NEVER SOMETIMES 1X/WEEK 1X/DAY AM 1X/DAY PM 2X/DAY >2X/DAY**

How often do you floss your teeth? **NEVER SOMETIMES 1X/WEEK 1X/DAY >1X/DAY**

Do your gums bleed when you brush or floss? **NEVER SOMETIMES ALWAYS**

Oral Habits: _____

YES NO DK Do you clench or grind your teeth? (Specify): **CLENCH GIND BOTH**

YES NO DK Do you chew on ice or potentially damaging objects (pencils, pens, etc)? **ICE OBJECTS BOTH**

_____ **Updated by Staff**

_____ **Updated by Staff**

DentalSpa

Medical History

Name_____ **Date:** _____/_____/_____

Address:_____ City:_____Zip:_____

Cell#:_____Work#:_____Email:_____

DOB:_____/_____/_____ Social Security #_____-_____-_____ Marital Status: S___M___D___W___P___

Employer:_____ Occupation:_____

Dental Insurance Co. Name:_____ Ins. Co. Ph#_____

Dental Ins. Co Address: _____ ID#_____

Emergency Contact:_____Phone:_____Relationship:_____

Who referred you to our office?_____**Relationship?**_____

Please circle your responses (Yes, No, DK = Don't know) to indicate if you have, have not, or do not know if you have had any of the following diseases or problems.

General Medical Information:

YES NO DK **Are you, or have you been in the past year, seen by a primary care provider (regular doctor) ?**
If yes, please list name, location, reason: _____
_____

YES NO DK **Are you seen by any medical specialists?**
If yes, please list name (s), location(s), reason(s): _____
_____

YES NO DK Have you had any serious illness, surgery or been hospitalized?
If yes, how long ago?

- **0/12 Months Specify:**_____
- **1-5 Years Specify:**_____
- **>5 Years Specify:**_____

YES NO DK Problems with General Anesthesia: Specify:_____

YES NO DK Do you have active tuberculosis or have you been exposed to anyone with tuberculosis?
Specify:_____

YES NO DK Have you had heart surgery? If yes, please specify: **STENTS VALVES BYPASS(CABG) OTHER:**_____

YES NO DK Have you had an organ/bone marrow transplant? Specify: **HEART LUNG KIDNEY LIVER BMT OTHER**

DATE:_____**ANY COMPLICATIONS:**_____

YES NO DK Do you now or have you ever had cancer? If yes, how was it treated?

- **Surgery**: diagnosis, site, when: _____
- **Radiation**: diagnosis, site, when: _____
- **Chemotherapy**: diagnosis, site, when: _____
- **Medication** to prevent or treat bone complications: If yes, please specify:_____
- **XGEVA** (Denosumab); **AREDIA** (Pamidronate); **ZOMETA** (Zoledronic Acid) – Length of time taken_____

ALLERGIES TO DRUGS, LATEX, METALS OR FOODS:

YES NO DK Are you allergic to or have you had a reaction to any of the following?

- **Local anesthetics (Lidocaine/Epinephrine)**
- **Penicillin**
- **Sufla Drugs**
- **Other antibiotics (Specify): _____**
- **Aspirin**
- **Advil (Ibuprofen)**
- **Tylenol (Acetaminophen)**
- **Codeine**
- **Opioids (hydrocodone, oxycodone)**
- **Chlorhexidine mouth rinse (Peridex/Periguard)**
- **Other Medications (Specify): _____**
- **Latex (rubber)**
- **Metals/Jewelry (nickel/chrome)**
- **Dietary allergies**

TYPE OF REACTION (S) TO ABOVE: _____

MEDICATIONS:

YES NO DK Are you taking, or are you supposed to be taking any medications? Prescription, over the counter, dietary supplements, herbal medicine or vitamins? If yes, please list below.

Medications or Supplements:	Dose (mg)	How Often:	Reason for use:	Date Started:

FEMALES ONLY:

YES NO DK Are you or could you be pregnant? If yes, number of weeks_____and due date: _____

YES NO DK Are you nursing?

YES NO DK Are you taking any of the following? (Specify):
BIRTH CONTROL FERTILITY DRUGS HORMONE REPLACEMENT OTHER:_____

YES NO DK Do you use or have you used tobacco products? IF yes, please specify type:
CIGARETTES E-CIGARETTES CIGARS PIPES HOOKAH SNUFF CHEW OTHER:_____

- **PAST:** When did you stop _____ How many years of use? _____
- **CURRENT:** How much do you smoke per day? _____ month? _____
- How interested are you in stopping? **VERY SOMEWHAT NOT INTERESTED**

YES NO DK Do you drink alcoholic beverages? If yes, how often? **_____days _____week _____month**

YES NO DK Do you use or have you used street drugs, prescription or other substances for recreational purposes?
____ Past ____ Current Are you drug dependent? Y N Last used:_____
(specify) Cocaine Ecstasy Heroin Marijuana Meth Opioids Other: _____

Eye/Ear/Nose/Throat Problems

If yes, please specify:

- Vision problems
- Corrective lenses
- Cataracts
- Glaucoma
- Macular Degeneration
- Hearing impairment
- Seasonal Allergies

Specify:_____

Heart/Blood Pressure problems

- High blood pressure
- High cholesterol/high triglycerides
- Infective endocarditis
- Congenital heart defect/disease
- Angina (chest pain)
- Heart attack
- Heart failure
- Coronary heart disease
- Arrhythmia
- Pacemaker/Implanted defibrillator
- Other: _____

Breathing/ Lung problems

- Asthma
- Emphysema/COPD
- Sinusitis
- Bronchitis
- Pneumonia
- Obstructive sleep apnea
- Use CPAP/Bi PAP
- Surgical correction
- Oral appliance
- Other:_____

Eating Disorder

- Bulimia
- Anorexia
- Other:_____

Skin Problem

- Specify _____

Stomach/Intestine/Liver disorder

- Acid reflex (GERD)
- Ulcers
- Crohn's disease
- IBS
- Ulcerative colitis
- Celiac disease
- Hepatitis
- A B/D C
- Cirrhosis

Other:_____

Kidney/Urinary disorder

- Chronic kidney disease
- Renal failure/Dialysis
- Bladder problems
- Urinary Incontinence
- Other: _____

Muscle/Bone Disorder

- Osteoarthritis
- Osteoporosis
- Osteopenia
- Gout
- TMJ
- Fibromyalgia
- Other: _____

Neurologic/Nerve problem

- Stroke
- TIA
- Seizures/Epilepsy
- Multiple sclerosis
- Parkinson's disease
- Neuropathies (numbness)
- Dementia/Alzheimer's
- Headache
- Other: _____

Mental Health disorder

- Bipolar disorder
- Depression
- Schizophrenia
- PTSD
- ADD/ADHD
- Generalized anxiety disorder
- Panic attacks
- Other: _____

Diabetes/Endocrine disorder

- Diabetes
  Type 1 or Type 2
- Thyroid problems
  Hypothyroidism
  Hyperthyroidism
- Other: _____

Blood/Hematologic disorder

- Anemia
- Sickle cell disease/trait
- Leukemia
- Lymphoma
- Multiple myeloma
- Bleeding disorders
- Hemophilia
- Von Willebrand
- Thrombocytopenia (low platelets)
- Other: _____

Immune System disorder

- Lupus erythematosus
- Rheumatoid arthritis
- Sjogren's syndrome
- Other: _____

Infectious disease

- HIV/AIDS
- STD
- Cold Sores
- Other _____

Do you have any other problem, disease or condition not listed above?

If yes, please specify:

_____

_____

_____

_____

Authorization and Release:

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing the incorrect or incomplete information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health care providers. I agree to be responsible for payment of all services rendered for myself including my dependents.

X_____ Date _____/_____/_____

Signature of Patient or Parent if Minor

Revised 3-15-17