

NAME: LAST

FIRST

MIDDLE INITIAL

DENTAL HISTORY:

PREVIOUS DENTIST'S NAME: _____ PHONE NUMBER: _____ - _____ - _____

DATE OF LAST EXAM: ____/____/____ ARE YOU UNDER DENTAL CARE ELSEWHERE? YES NO

DO YOU CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? YES NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? YES NO
HAVE YOUR PARENTS EXPERIENCED GUM DISEASE OR TOOTH LOSS? YES NO
ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? YES NO

ARE YOU SENSITIVE TO OR DO THE FOLLOWING:

SWEET OR SOUR LIQUIDS OR FOODS? YES NO
HOT OR COLD LIQUIDS OR FOODS? YES NO
BITING OR CHEWING? YES NO
BITE YOUR CHEEKS OR LIPS REGULARLY? YES NO
FEEL PAIN IN ANY OF YOUR TEETH? YES NO

HAVE YOU NOTICED:

CLICKING IN YOUR JAW YES NO
PAIN (JOINT, EAR, SIDE OF FACE) YES NO
PAIN WHEN OPENING/CLOSING YES NO
TIRED JAWS IN THE MORNING YES NO
NECK OR SHOULDER ACHES YES NO
DIFFICULTY CHEWING YES NO
MOUTH ODORS OR BAD TASTES YES NO
SORES OR LUMPS IN/NEAR YOUR MOUTH YES NO

HAVE YOU HAD ANY OF THE FOLLOWING:

ORTHODONTIC TREATMENT YES NO
PERIODONTAL TREATMENT YES NO
ORAL SURGERY YES NO
A BITE PLATE OR MOUTHGUARD YES NO
YOUR TEETH GROUND YES NO
YOUR BITE ADJUSTED YES NO

MEDICAL HISTORY:

PHYSICIAN'S NAME: _____ PHONE: ____/____/____

HAVE YOU BEEN HOSPITALIZED FOR SURGICAL CARE OR SERIOUS ILLNESS WITHIN THE LAST FIVE (5) YEARS? YES NO

ARE YOU TAKING **ANY MEDICATION(S)** SUCH AS FOSAMAX OR ANY MEDICATION FOR OSTEOPOROSIS INCLUDING VITAMINS OR NON-PRESCRIPTION MEDICINE? YES NO IF YES, PLEASE PROVIDE SPECIFIC DETAILS BELOW:

DO YOU USE TOBACCO? YES NO DO YOU USE EXTRA PILLOWS TO SLEEP? YES NO
DO YOU USE CONTROLLED SUBSTANCES? YES NO

WOMEN ONLY:

ARE YOU TAKING ORAL CONTRACEPTIVES? YES NO HAVE YOU ENTERED MENOPAUSE? YES NO
ARE YOU PREGNANT? YES NO DO YOU TAKE ESTROGEN? YES NO
ARE YOU NURSING? YES NO IF SO, WHAT TYPE? _____

PLEASE CONTINUE TO THE NEXT PAGE

MEDICAL HISTORY CONTINUED:



