BELLINGHAM BAY DENTAL

Medical History

Patient Name _____ **Nickname** _____ **Age** _____
Name of Physician/ and their specialty _____
Most recent physical _____ **Purpose** _____

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to		
○ aspirin, ibuprofen, acetaminophen		
○ penicillin		
○ erythromycin		
○ tetracycline		
○ codeine		
○ local anesthetic		
○ metals		
○ latex		
○ any other medications _____		
3. heart problems_____	☐	☐
4. heart murmur _____	☐	☐
5. rheumatic fever_____	☐	☐
6. scarlet fever_____	☐	☐
7. high blood pressure_____	☐	☐
8. low blood pressure_____	☐	☐
9. a stroke_____	☐	☐
10. artificial prosthesis (i.e. heart valve or joints) _	☐	☐
11. anemia or other blood disorder_____	☐	☐
12. prolonged bleeding due to a slight cut_____	☐	☐
13. emphysema_____	☐	☐
14. tuberculosis_____	☐	☐
15. asthma_____	☐	☐
16. breathing or sleep problems_____	☐	☐
17. kidney disease_____	☐	☐
18. liver disease_____	☐	☐
19. jaundice_____	☐	☐
20. thyroid or parathyroid disease_____	☐	☐
21. hormone deficiency_____	☐	☐
22. high cholesterol_____	☐	☐
23. diabetes_____	☐	☐
24. stomach or duodenal ulcer_____	☐	☐
25. digestive disorders (i.e. gastric reflux)_____	☐	☐

	YES	NO
26. osteoporosis (i.e. taking bisphosphonates)_____	☐	☐
27. arthritis_____	☐	☐
28. glaucoma_____	☐	☐
29. contact lenses_____	☐	☐
30. head or neck injuries_____	☐	☐
31. epilepsy, convulsions (seizures)_____	☐	☐
32. neurologic problems_____	☐	☐
33. viral infections and cold sores_____	☐	☐
34. any lumps or swelling in the mouth_____	☐	☐
35. hives, skin rash, hay fever_____	☐	☐
36. venereal disease_____	☐	☐
37. hepatitis (type ___)_____	☐	☐
38. HIV/AIDS_____	☐	☐
39. tumor, abnormal growth_____	☐	☐
40. radiation therapy_____	☐	☐
41. chemotherapy_____	☐	☐
42. emotional problems_____	☐	☐
43. psychiatric treatment_____	☐	☐
44. antidepressant medication_____	☐	☐
45. alcohol / drug dependency_____	☐	☐
ARE YOU:		
46. presently being treated for any other illness_____	☐	☐
47. aware of a change in your general health_____	☐	☐
48. taking medication for weight loss_____	☐	☐
49. taking dietary supplements_____	☐	☐
50. often exhausted or fatigued_____	☐	☐
51. subject to frequent headaches_____	☐	☐
52. a smoker or smoked previously_____	☐	☐
53. often unhappy or depressed_____	☐	☐
54. FEMALE – taking birth control pills_____	☐	☐
55. FEMALE – pregnant_____	☐	☐
56. MALE – prostate disorders_____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements and or vitamins that you are taking.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Dental History

Referred by_____
Previous Dentist_____
Date of most recent dental visit _____/_____/_____ Date of most recent x-rays _____/_____/_____
I have routinely seen my dentist every: ☐3 mo. ☐4mo. ☐6 mo. ☐12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN?_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? Scale of 1 to 10_____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or reactions to local anesthetics? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you had any teeth removed? _____	☐	☐
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
8. Have you ever whitened (bleached) your teeth? _____	☐	☐
9. Are you self-conscious about your teeth? _____	☐	☐
10. Have you been disappointed with the appearance of previous dental work? _____	☐	☐
BITE AND JAW JOINT		
11. Do you/ would you have any problem chewing gum? _____	☐	☐
12. Do you/ would you have any problem chewing bagels or other hard foods? _____	☐	☐
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
14. Are your teeth crowding or developing spaces? _____	☐	☐
15. Do you have more than one bite or do you clench to make your teeth fit together? _____	☐	☐
16. Do you have any problem with sleep or wake up with awareness of your teeth? _____	☐	☐
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
18. Do you have tension headaches or sore teeth? _____	☐	☐
19. Do you wear or have you ever worn a bite appliance? _____	☐	☐
TOOTH STRUCTURE		
20. Have you had any cavities within the past 3 years? _____	☐	☐
21. Do you have a dry mouth? _____	☐	☐
22. Are any teeth sensitive to hot, cold, biting or sweets? _____	☐	☐
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____	☐	☐
24. Do you avoid brushing any part of your mouth? _____	☐	☐
25. Do you feel or notice any holes in your teeth? _____	☐	☐
GUM AND BONE		
26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____	☐	☐
27. Have you ever experienced gum recession? _____	☐	☐
28. Is there anyone with a history of periodontal disease in you family? _____	☐	☐
29. Do your gums bleed when brushing, flossing or eating? _____	☐	☐
30. Are your teeth becoming loose? _____	☐	☐
31. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐

Patient's Signature _____**Date** _____