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DENTAL HISTORY:

Patient's General Dentist: _____ Address: _____

Date of Last Dental Visit: _____

***Circle Yes or No to the following*:

Patient brushes teeth conscientiously? Yes No Patient follows directions? Yes No

Any history of the following:

Yes	*No*	*Removal of teeth*	*Yes*	*No*	*Sensitive teeth*
Yes	*No*	*Sore, bleeding gums*	*Yes*	*No*	*Gum treatment*
Yes	*No*	*Root canal work*	*Yes*	*No*	*Oral surgery*

If "yes" to any of the above, please explain: _____

Yes	*No*	*Grinds teeth at night*	*Yes*	*No*	*Clenches teeth at night*
Yes	*No*	*Breathes through mouth at night*	*Yes*	*No*	*Clicking or popping of jaws*
Yes	*No*	*Pain or aching of the lower jaw joint(s)*			

If pain or ache of the lower jaw joint(s), please explain: _____

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MEDICAL HISTORY:

Patient's Primary Physician: _____ Address: _____

Yes	*No*	*Operations or injury to teeth or jaws*	*Yes*	*No*	*Joint problems*
Yes	*No*	*Severe headaches*	*Yes*	*No*	*Heart disease*
Yes	*No*	*Sinus trouble*	*Yes*	*No*	*Hepatitis*
Yes	*No*	*Frequent colds*	*Yes*	*No*	*Liver disorder*
Yes	*No*	*Persistent cough*	*Yes*	*No*	*Kidney disorder*
Yes	*No*	*Tonsillitis*	*Yes*	*No*	*Diabetes*
Yes	*No*	*Frequent sore throats*	*Yes*	*No*	*Endocrine disturbance*
Yes	*No*	*Deviated septum of the nose*	*Yes*	*No*	*Convulsions*
Yes	*No*	*Anemia*	*Yes*	*No*	*Venereal disease*
Yes	*No*	*Bleeding problems*	*Yes*	*No*	*Acquired immune deficiency*
Yes	*No*	*Tuberculosis*	*Yes*	*No*	*Speech problem*
Yes	*No*	*Rheumatic fever*	*Yes*	*No*	*Behavioral or emotional problems*
Yes	*No*	*High or low blood pressure*			

Yes *No* *Are there any other medical conditions we should be aware of?*
Describe: _____

_____

Yes *No* *Allergies to any medicines or other substances (i.e. latex, metal)? Please list:* _____

_____

Yes	*No*	*Is patient in good health?*	*Yes*	*No*	*Any serious illnesses?*
Yes	*No*	*Any change in general health within the past year?*	*Yes*	*No*	*Is patient currently under a physician's care?*
Yes	*No*	*Has patient ever been hospitalized?* *For what reason:* _____ _____	*Yes*	*No*	*Has patient ever had surgery?* *Please describe:* _____ _____
Yes	*No*	*Have tonsils and/or adenoids been removed?*	*Yes*	*No*	*Sudden increase in height?*
Yes	*No*	*If a male, has patient started to shave?*	*Yes*	*No*	*If female, has patient started to menstruate?*
Yes	*No*	*Is your child's development within his/her age group? Earlier* ☐ *Later* ☐			

**Please list any current medications you are currently taking and the reason for which you are taking them: _____

_____

_____