Gentling Dental Care

Medical History

Patient Name _____ Nickname_____ Age_____

Name of Physician/ and their specialty _____

Most recent physical examination _____ Purpose_____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

Antibiotic PRE-MED: Do you require antibiotics prior to dental treatment? ☐Yes ☐No

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to		
☐aspirin, ibuprofen, acetaminophen, codeine		
☐penicillin		
☐other antibiotics _____		
☐local anesthetic		
☐metals (nickel, gold, silver)		
☐latex		
☐other _____		
3. heart problems, or cardiac stent within the last 6 months _	☐	☐
4. history of infective endocarditus _____	☐	☐
5 artificial heart valve, repaired heart defect _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. high or low blood pressure _____	☐	☐
9. a stroke _____	☐	☐
10. anemia or other blood disorder_____	☐	☐
11. prolonged bleeding due to a slight cut (INR >3.5) _____	☐	☐
12. Coumadin / Warfarin Use _____	☐	☐
13. tuberculosis _____	☐	☐
14. asthma _____	☐	☐
15. breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
16. kidney disease _____	☐	☐
17. liver disease _____	☐	☐
18. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
19. diabetes _____	☐	☐
20. digestive disorders (i.e. heartburn or gastric reflux) _____	☐	☐

	YES	NO
21. osteoporosis / osteopenia_____	☐	☐
22. history of bisphoiphonate use (Actonel®, Boniva®, Fosamax®, Aredia®, Zometa®, etc.) _____	☐	☐
23. arthritis _____	☐	☐
24. glaucoma_____	☐	☐
25. head or neck injuries _____	☐	☐
26. epilepsy, convulsions _____	☐	☐
27. viral infections and cold sores _____	☐	☐
28. any lumps or swelling in the mouth _____	☐	☐
29. hepatitis (type_____) _____	☐	☐
30. HIV / AIDS _____	☐	☐
31. tumor / abnormal growth _____	☐	☐
32. radiation therapy _____	☐	☐
33. chemotherapy _____	☐	☐
34. psychiatric treatment _____	☐	☐
35. antidepressant medication _____	☐	☐
36. alcohol abuse / addiction _____	☐	☐
37. street drug abuse / addiction _____	☐	☐
ARE YOU:		
38. presently being treated for any other illness_____	☐	☐
39. aware of a change in your health (i.e. fever, new cough)__	☐	☐
40. often exhausted or fatigued _____	☐	☐
41. experiencing frequent headaches _____	☐	☐
42. a smoker, smoked previously or use smokeless tobacco _	☐	☐
43. often unhappy or depressed _____	☐	☐
44. FEMALE - pregnant / nursing _____	☐	☐

Descibe any medical treatment, impending surgery, genetic / developmental anomalies, or other medical concerns that may possibly affect your dental treatment.

_____

List all current medication and dosages. (Including aspirin, birth control pills, vitamins, herbal suppliments, blood thinners, etc.)

Drug	Dose	Drug	Dose

Ask for additional sheet if you are taking more than 6 medications

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

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Gentling Dental Care

DENTAL HISTORY

Name_____ Age _____

How would you rate your mouth? ☐Excellent ☐Good ☐Poor

Previous Dentist _____

Date of most recent dental exam _____/ _____/ _____ Date of most recent x-rays _____/ _____/ _____

Date of most recent treatment (other than cleaning) _____/ _____/ _____

I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6mo. ☐12mo. ☐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? How fearful on a scale of 1(least) to 10(most) _____	☐	☐
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 had any reactions to local anesthetic?_____	☐	☐
5. Did you ever have braces, orthodontic treatment or have 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. Have you felt uncomfortable or self conscious about the appearance of your teeth?_____	☐	☐
10. Have you been disappointed with the appearance of your previous dental work?_____	☐	☐
Bite and Jaw Joint		
11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking)_____	☐	☐
12. Do you / would you have problems chewing bagels, hard foods, or gum?_____	☐	☐
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 and squeeze to make your teeth fit together?_____	☐	☐
16. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____	☐	☐
17. Do you clench your teeth in the daytime or make them sore?_____	☐	☐
18. Do you have any problems sleeping or wake up with an awareness of your teeth?_____	☐	☐
19. Do you wear or have you ever worn a bite appliance (night guard)?_____	☐	☐
Tooth Structure		
20. Have you had any cavities within the past 3 years?_____	☐	☐
21. Do you have a dry mouth or difficulty swallowing food?_____	☐	☐
22. Are any teeth sensitive to hot, cold, biting or sweets?_____	☐	☐
23. Have you ever broken teeth, chipped teeth. or had a toothache or cracked filling?_____	☐	☐
24. Do you frequently get food caught between any teeth?_____	☐	☐
Gum and Bone		
25. Do your gums bleed or are they painful when brushing any part of your mouth or flossing ?_____	☐	☐
26. Have you ever been treated for gum disease or been told you have lost bone around your teeth?_____	☐	☐
27. Have you ever noticed an unpleasant taste or odor in your mouth?_____	☐	☐
28. Is there anyone with a history of periodontal desease in your family?_____	☐	☐
29. Have you experienced gum recession?_____	☐	☐
30. Have you had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
31. Have you experienced a burning senastion in your mouth?_____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____