MEDICAL HISTORY

Full name: _____ Preferred 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

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:		
☐aspirin, ibuprofen, acetaminophen, codeine		
☐penicillin		
☐erythromycin		
☐tetracycline		
☐sulfa		
☐local anesthetic		
☐fluoride		
☐metals (nickel, gold, silver, _____)		
☐latex		
☐nuts _____		
☐fruit _____		
☐other _____		
3. heart problems or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR >3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis __	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing/sleep problems (i.e. sleep apnea, snoring, sinus)__	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c=_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25 digestive or eating disorders (eg. celiac, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (ie. taking bisphosphonates) ____	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (ie. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type _____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (ie. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco__	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment (ie. Botox, collagen injections).

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATION CHANGES.

Patient's Signature _____ Date: _____

Doctor's Signature _____ Date: _____

ORCHARDS DENTAL
CLINIC

DENTAL HISTORY

Referred by: _____

Previous Dentist _____ How long have you been a patient _____Months/years

Date of most recent dental exam ____/____ (month/year) Date of most recent x-rays ____/____ (month/year)

Date of most recent treatment (other than a cleaning) ____/____ (month/year)

I routinely see a dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ not routinely

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

WHAT IS YOUR IMMEDIATE CONCERN?_____

_____

How did you hear about Orchards Dental? _____

Personal History	Yes	No
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 dental anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	☐	☐
Gums and Bone	Yes	No
7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease (gum disease) in your family? _____	☐	☐
11. Have you ever experienced gum recession? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐
Tooth Structure	Yes	No
14. Have you had any cavities in the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are your teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?_____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you often get food caught between any teeth? _____	☐	☐
Bite and Jaw Joint	Yes	No
21. Do you have any problems with your jaw joint (pain, sounds, limited opening, locking, popping)? _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. Have your teeth changed (become shorter, thinner, or worn) in the past 5 years? _____	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26. Are your teeth developing spaces or becoming more loose? _____	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore? _____	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _	☐	☐
32. Do you wear or have you ever worn a bite appliance? _____	☐	☐
Smile Characteristics	Yes	No
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____	☐	☐
34. Have you ever whitened (bleached) your teeth? _____	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36. Have you been disappointed with the appearance of previous dental work? _____	☐	☐
37. Are you interested in straightening your teeth? _____	☐	☐
Airway	Yes	No
38. Has anyone observed you stop breathing or choking or gasping during your sleep? _____	☐	☐
39. Do you snore in your sleep? _____	☐	☐
40. Do you often feel tired or sleepy or fatigued during the day? _____	☐	☐
41. Do you use a CPAP machine? _____	☐	☐

Patient's Signature _____ Date: _____

Doctor's Signature _____ Date: _____

PERSONAL INFORMATION

Email Address: _____
Address: _____
Postal Code: _____

Date of birth: _____
Phone #: _____

Emergency Contact Name: _____
Emergency Contact Phone #: _____