MEDICAL HISTORY

Patient Name _____ DOB _____ Today's date _____

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. an allergic or bad reaction to any of the following:		
• aspirin, ibuprofen, acetaminophen, codeine	☐	☐
• erythromycin	☐	☐
• sulfa	☐	☐
• fluoride	☐	☐
• iodine	☐	☐
• latex	☐	☐
• fruit	☐	☐
• metals (nickel, gold, silver, _____)	☐	☐
2. hospitalization for illness or injury	☐	☐
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 or soft tissue implant (joint replacement breast implants)	☐	☐
8. heart murmur, 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 (or INR > 3.5)	☐	☐
13. pneumonia, emphysema, shortness of breath sarcoidosis	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox	☐	☐
15. breathing problems (asthma, nasal breathing, stuffy nose, sinus congestion)	☐	☐
16. sleep problems (sleep apnea, snoring, insomnia, restless sleep, bedwetting)	☐	☐
17. kidney disease	☐	☐
18. liver disease or jaundice	☐	☐
19. vertigo ("the room is spinning)	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency or imbalance (polycystic ovarian syndrome)	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. digestive or disorders (acid reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease)	☐	☐

	YES	NO
penicillin	☐	☐
tetracycline	☐	☐
local anesthetic	☐	☐
chlorhexidine (CHX)	☐	☐
red dye	☐	☐
nuts	☐	☐
milk	☐	☐
other	☐	☐
24. stomach duodenal ulcer	☐	☐
25. diabetes (Type____)(HbA1c=_____)	☐	☐
26. osteoporosis/osteopenia or ever taken antiresorptive medications (bisphosphonates)	☐	☐
27. arthritis or gout	☐	☐
28. autoimmune disease (rheumatoid arthritis lupus, scleroderma)	☐	☐
29. glaucoma	☐	☐
30. head or neck injuries	☐	☐
31. epilepsy, convulsions (seizures)	☐	☐
32. neurologic disorders (Alzheimer's disease, dementia, prion disease)	☐	☐
33. viral infections (cold sores) bacterial infections (Lyme disease)	☐	☐
34. any lumps or swelling in the mouth	☐	☐
35. hives, skin rash, hay fever	☐	☐
36. STI/STD/HPV	☐	☐
37. hepatitis (type_____)	☐	☐
38. HIV/AIDS	☐	☐
39. tumor, abnormal growth	☐	☐
40. radiation therapy	☐	☐
41. chemotherapy, immunosuppressive medication	☐	☐
42. difficulties with stress management	☐	☐
43. psychiatric treatment, antidepressants, mood stabilizing medications	☐	☐
44. concentration problems or ADD/ADHD	☐	☐
45. alcohol/recreational drug use	☐	☐

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medical history continued

ARE YOU:	YES	NO
46. presently being treated for any other illness	☐	☐
47. aware of a change in your health in the last 24 hours (fever, chills, new cough, or diarrhea)	☐	☐
48. taking medication for weight management	☐	☐
49. taking dietary supplements, vitamins, and/or probiotics	☐	☐
50. often exhausted or fatigued	☐	☐
51. experiencing frequent headaches or chronic pain	☐	☐
52. a smoker, smoked previously or other (smokeless tobacco, vaping, e-cigarettes, or cannabis)	☐	☐
53. considered a touchy / sensitive person (often unhappy or depressed)	☐	☐
54. required to take antibiotics prior to dental treatment	☐	☐
55. **FEMALE QUESTIONS** currently pregnant	☐	☐
56. on birth control	☐	☐
57. **MALE QUESTIONS** diagnosed with prostate disorder	☐	☐

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, vitamins, and/or probiotics 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 MEDICATIONS YOU MAY BE TAKING.

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Arlington Advanced Dentistry will not use provided information to discriminate. Your answers are for our records ONLY and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital in the appropriate rendering of your care.

I certify that I have read and fully understand the statements provided above. I acknowledge that all of my questions, if any, regarding the inquiries in this form have been answered to my satisfaction. I understand the importance of providing truthful information for my dentist and staff to rely on. The information provided on this form is accurate and complete, and I will not hold Arlington Advanced Dentistry doctors or staff, responsible for any errors resulting from intentional or accidental omissions made in the completion of this form.

Signature _____ Date _____

DENTAL HISTORY

Patient Name _____ DOB _____ Today's Date _____

How often do you have dental cleanings? ☐ 3mo ☐ 4mo ☐ 6mo ☐ 12mo ☐ Not routinely

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

Date of most recent treatment (other than cleaning) _____ Referred by _____

What type of toothbrush do you use? ☐ manual ☐ electric How often do you floss? _____

Previous Dentist _____ For how long? _____

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

What is your immediate concern? _____

_____

PLEASE ANSWER THE FOLLOWING:

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 local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment, or had your bite adjusted? _____	☐	☐
a. If so, at what age? _____		
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	☐	☐

GUM AND BONE	YES	NO
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8. Have you ever had or been told that you have gum loss, gum disease, or bone loss between your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth or swollen and puffy gums?	☐	☐
10. Is there anyone with a history of periodontal disease in your family or history of loosing all their teeth? _____	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? _____	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? _____	☐	☐

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? _____	☐	☐
16. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
17. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
18. Have you ever broken teeth, chipped teeth, or had a toothache, or cracked filling? _____	☐	☐
19. Do you frequently get food caught between any teeth? _____	☐	☐

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BITE AND JAW JOINT	YES	NO
20. Does your jaw joint ever have pain, sounds (popping, cracking) or experience limited opening or locking?	☐	☐
21. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐	☐
22. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
23. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
24. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
25. Are your teeth developing spaces or becoming more loose?	☐	☐
26. Do you have more than one bite or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	☐	☐
27. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
28. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habit?	☐	☐
29. Do you clench or grind your teeth together in the daytime/nighttime or ever make them sore?	☐	☐
30. Do you have any problems with sleep (restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
31. Have you ever had a sleep study or been diagnosed with sleep apnea?	☐	☐
32. Do you wear or have ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth gums) that you would like to change? (color, spaces, size, shape, display)?	☐	☐
34. Have you ever bleached (whitened) 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?	☐	☐

Patient's Signature _____ Date _____

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