WERSCHKY & LEWIS
family dentistry

PLEASE PRINT

# DENTAL HISTORY

Patient Name ______________ Nickname ______________ Age ______

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

Previous Dentist ______________ How long have you been a patient? ______________ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

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

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

**WHAT IS YOUR IMMEDIATE CONCERN?** ______________

## PLEASE ANSWER YES OR NO TO 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, 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? | | | | ☐ | ☐ |

| GUM 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 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 within 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 any 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 frequently get food caught between any teeth? | | | | ☐ | ☐ |

| BITE AND JAW JOINT | ○ | ○ | ○ | YES | NO |
|---|---|---|---|---|---|
| 21. Do you have 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. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? | | | | ☐ | ☐ |
| 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? | | | | ☐ | ☐ |

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*PLEASE TURN OVER, COMPLETE AND SIGN REVERSE SIDE*

# MEDICAL HISTORY

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 | | |
| ☐ chlorhexidine (CHX) | | |
| ☐ 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. chronic ear infections, tuberculosis, measles, chicken pox ______ | ☐ | ☐ |
| 15. asthma ______ | ☐ | ☐ |
| 16. breathing or sleep problems (e.g., 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 (e.g., celiac disease, gastric reflux, bulimia, anorexia) ______ | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 26. osteoporosis/osteopenia (e.g., taking bisphosphonates) ______ | ☐ | ☐ |
| 27. arthritis ______ | ☐ | ☐ |
| 28. autoimmune disease ______ (e.g., 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. HPV Vaccine? ______ | ☐ | ☐ |
| 39. hepatitis (type ____ ) ______ | ☐ | ☐ |
| 40. HIV/AIDS ______ | ☐ | ☐ |
| 41. tumor, abnormal growth ______ | ☐ | ☐ |
| 42. radiation therapy ______ | ☐ | ☐ |
| 43. chemotherapy, immunosuppressive medication ______ | ☐ | ☐ |
| 44. emotional difficulties ______ | ☐ | ☐ |
| 45. psychiatric treatment ______ | ☐ | ☐ |
| 46. antidepressant medication ______ | ☐ | ☐ |
| 47. alcohol/recreational drug use ______ | ☐ | ☐ |

### ARE YOU:

| | YES | NO |
|---|---|---|
| 48. presently being treated for any other illness ______ | ☐ | ☐ |
| 49. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) ______ | ☐ | ☐ |
| 50. taking medication for weight management ______ | ☐ | ☐ |
| 51. taking dietary supplements ______ | ☐ | ☐ |
| 52. often exhausted or fatigued ______ | ☐ | ☐ |
| 53. experiencing frequent headaches ______ | ☐ | ☐ |
| 54. a smoker, smoked previously or use smokeless tobacco ______ | ☐ | ☐ |
| 55. considered a touchy/sensitive person ______ | ☐ | ☐ |
| 56. often unhappy or depressed ______ | ☐ | ☐ |
| 57. taking birth control pills ______ | ☐ | ☐ |
| 58. currently pregnant ______ | ☐ | ☐ |
| 59. diagnosed with a prostate disorder ______ | ☐ | ☐ |

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. 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 MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature ______ Date ______

Doctor's Signature ______ Date ______

ASA ______ (1-6) ◯ ◯ ◯

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