Smiles For Life Dentistry

Name_____ Date_____ Age_____

Thank you for taking the time to provide us with a thorough dental/medical history. The more we are informed, the better we can care for you.

What are your concerns and goals for your mouth?_____

_____.

Please place an "X" for any "Yes" answers.

___Are you currently in pain? ___Do you like your smile?

___Would you like whiter teeth?

Your current dental health is ___Good ____Fair ____Poor Last dental visit?_____

Caries (Tooth Decay)

____Do you consider yourself cavity prone?
____Do you consume acidic/ sugary beverages or foods on a regular basis?
____Does your mouth feel dry?
____Do you have heartburn or reflux?
____Family History of Tooth Decay?

Periodontal (Gum) Disease

____Have you ever been told you have gingivitis or gum disease in the past?
____Do your gums ever bleed when you brush or floss?
____Do you have gum recession or exposed root surfaces?
____Do you have any loose teeth, drifting teeth or areas that collect food when you eat?
____Family History of Gum Disease?
____Have you ever had Root Planing & Scaling or Gum Disease treatment?

Oral Cancer

____Do you smoke or chew tobacco? How often and how much?_____
____Do you have any persistent sore spots in your mouth or lumps/bump in your head or neck?
____Do you have difficulty swallowing?
____Family History of Oral Cancer

Function/Bite/TMJ Dysfunction:

____Do you have any missing teeth other than wisdom teeth?
____Do you experience frequent headaches or jaw/facial pain?
____Do your jaw joints ever get stuck or locked?
____Have you ever been treated for a jaw joint problem?
If so, by what methods:
____Do you feel like you clench or grind your teeth?
____Do you use a bite guard at night?
____Do you wear any removable dentures or partial dentures?
If so, are they comfortable and well-fitting? _____

Pre-diabetes and Diabetes:

____Have you ever been diagnosed with prediabetes or diabetes?
____Do you take medications for diabetes?
____What was your last A1c?
____Family History of Diabetes?

Cardiovascular Health:

____Do you need to take pre-med antibiotics prior to your dental visits due to artificial joints or valves?
____Are you currently being treated for high blood pressure or cardiovascular disease?
____Is there family history of heart disease?
Have you ever had:
____Heart Attack
____Stroke
____Heart Murmur
____Bypass surgery
____Stents
___Rheumatic or Scarlet Fever
___Pacemaker
___Mitral Valve Prolapse
___Heart Valves/Joints Replaced
___Cholesterol Issues

Brain Health:

____Do you experience "brain fog" or lack of clear/focused thinking?
____Do you have difficulty remembering names?
Have you ever been diagnosed with:
____Alzheimer's
____Dementia
____Anxiety Disorder
____Other brain related ailments
____Family History of any of these?
____Parkinson's
____ADD/ADHD
____Seizures, Epilepsy, Convulsions
____Autism
____Depression

Major Organ Health:

___ Kidney disease
____Liver disease
____Thyroid issues
____Crohns disease

Digestive Health:

____Stomach or intestinal ulcer
____Acid reflux or heartburn
____Celiac disease
____Colitis

Joint Health:

____History of joint surgery or joint replacement
____Do you have any type of arthritis?
____Family history of arthritis?
____Joint Pain
____Do you need to take antibiotic pre-med before your dental visits?

Other Conditions:

____Lupus
____Hepatits
____Anemia or other blood disorder
____Emphysema, shortness of breath or chest pains
____Tuberculosis, measles or chicken pox or shingles
____Osteoporosis/osteopenia(taking bisphosphonate)
____Hormone Deficency
____Head & Neck Injuries
____Allergies
____Asthma
____Prone to cold sores or canker sores
____Shingles
____HIV/AIDS
____History of any type of cancer/chemotherapy/ radiation therapy
____Sleep problems (snoring, sleep apnea, sinus issues, irregular sleep) ____Do you use a CPAP machine?
____Family History of Sleep Apnea
____Alcohol/drug abuse
____Do you use medical marijauna?

Women:

____Are you taking a prescribed method of birth control?
____Are you pregnant? Week#_____
____Are you nursing?

List of Medications and Physician Information

Medication & Dose: **Reason for Taking:** **Medication & Dose** **Reason for Taking:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Supplements/ Vitamins

_____ _____
_____ _____
_____ _____

Allergies to drugs/materials:

_____
_____
_____

Please provide us with information about your medical team.

Physican: Specialty: Phone Number:

_____
_____
_____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature **Date**