# PATIENT MEDICAL & DENTAL HISTORY- INNOVATIVE DENTISTRY

**PATIENT NAME:** ______________________ **DOB:** ______________ **Date:** ______________

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | AIDS | ☐ | ☐ | Headaches | ☐ | ☐ | Scarlet Fever |
| ☐ | ☐ | Anemia | ☐ | ☐ | Heart Problems or Disease | ☐ | ☐ | Scarring / Keloids |
| ☐ | ☐ | Arthritis, Rheumatism | ☐ | ☐ | Hepatitis – type: | ☐ | ☐ | Seizures / Convulsions |
| ☐ | ☐ | Asthma | ☐ | ☐ | Herpes | ☐ | ☐ | Shortness of Breath |
| ☐ | ☐ | Back Problems | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Sinus Trouble |
| ☐ | ☐ | Cancer | ☐ | ☐ | HIV Positive | ☐ | ☐ | Skin Rash |
| ☐ | ☐ | Carotid Artery Disease | ☐ | ☐ | Jaundice | ☐ | ☐ | Special Diet / Weight Loss |
| ☐ | ☐ | Chemical Dependency | ☐ | ☐ | Jaw Pain | ☐ | ☐ | Spinal Injury |
| ☐ | ☐ | Chemotherapy | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Stroke |
| ☐ | ☐ | Circulatory Problems | ☐ | ☐ | Liver Disease | ☐ | ☐ | Swollen Feet or Ankles |
| ☐ | ☐ | Cortisone Treatments | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Swollen Neck Glands |
| ☐ | ☐ | Cough | ☐ | ☐ | Lung Disease | ☐ | ☐ | Temporal Arteritis |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Migraines | ☐ | ☐ | Thyroid Problems |
| ☐ | ☐ | Emphysema | ☐ | ☐ | Nervous Problems | ☐ | ☐ | Tonsilitis |
| ☐ | ☐ | Epilepsy | ☐ | ☐ | Neurological Disease | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Fainting or Dizziness | ☐ | ☐ | Prostate Disorder | ☐ | ☐ | Tumors or Growths |
| ☐ | ☐ | Gastrointestinal Disease | ☐ | ☐ | Psychiatric Disorder or Care | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Glaucoma | ☐ | ☐ | Radiation Treatment | ☐ | ☐ | Venereal Disease |
| ☐ | ☐ | Head Injury | ☐ | ☐ | Respiratory Disease | ☐ | ☐ | Other |

## DENTAL HISTORY

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Bad Breath | ☐ | ☐ | Food collection in teeth | ☐ | ☐ | Mouth pain |
| ☐ | ☐ | Bleeding Gums | ☐ | ☐ | Foreign objects in mouth | ☐ | ☐ | Orthodontics |
| ☐ | ☐ | Blisters (mouth or lips) | ☐ | ☐ | Grinding teeth | ☐ | ☐ | Pain around ear |
| ☐ | ☐ | Burning Sensation | ☐ | ☐ | Gums swollen/tender | ☐ | ☐ | Periodontal treatment |
| ☐ | ☐ | Chewing on one side | ☐ | ☐ | Jaw pain/tiredness | ☐ | ☐ | Sensitivity to cold |
| ☐ | ☐ | Clicking or Popping Jaw | ☐ | ☐ | Lip or cheek biting | ☐ | ☐ | Sensitivity to heat |
| ☐ | ☐ | Dry Mouth | ☐ | ☐ | Loose teeth / broken fillings | ☐ | ☐ | Sensitivity to sweets |
| ☐ | ☐ | Fingernail biting | ☐ | ☐ | Mouth breathing | ☐ | ☐ | Other |

__________ Date of last dental visit?

__________ Date of last full mouth x-rays?

__________ Date of last dental cleaning?

__________ How often do you have dental examinations?

__________ How often do you brush/floss?

__________ What other dental aids do you use?

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## ADDITIONAL QUESTIONS

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Do you drink? # per day ______ |
| ☐ | ☐ | Do you smoke? # per day ______ |
| ☐ | ☐ | Do you vape? ☐ Cannabis ☐ Nicotine |
| ☐ | ☐ | Do you use any edible cannabis or CBD products? |
| ☐ | ☐ | Pregnant or nursing? |
| ☐ | ☐ | Have you ever taken an antibiotic prior to dental treatment? |
| ☐ | ☐ | Are you satisfied with your teeth's appearance? |
| ☐ | ☐ | Would you like to keep your teeth all your life? |

**Previous hospitalizations / surgeries**

______

**Current medications**

______

**Allergies**

______

**Other medical concerns**

______

**Previous Dentist's name**

______

**What is the reason for your visit today?**

______

**Do you have any dental problems now?** If yes, please describe

______

**Do you feel nervous about having dental treatment?** if yes, what is your biggest concern?

______

**Have you ever had an upsetting dental experience?** If yes, please describe

______

**Who may we thank for referring you to our office?**

______

**Patient / Guardian Name:** ______

**Patient / Guardian Signature:** ______ **Date:** ______