TYMA, TRACHTENBERG
BULLOCK & BLESSINGTON

Center *for* Contemporary Dental Health

Dental History

1. What is the primary reason for your dental visit today? _____

_____

_____

2. Have you had any extensive dental work in the past? If yes, please explain. _____

_____

_____

3. Have you seen a periodontist, oral surgeon, or orthodontist in the past? If so, for what reason? _____

_____

_____

4. Do you currently have any of the following?

- ☐ Bleeding gums
- ☐ Missing Teeth
- ☐ Bad Breath
- ☐ Dry Mouth
- ☐ Tenderness when chewing
- ☐ Sensitivity to hot, cold or sweets
- ☐ Frequent headaches or jaw pain
- ☐ Night guard to prevent tooth grinding
- ☐ Orthodontic retainers
- ☐ Other concern _____

5. How would you rate your current dental health on a scale of 1-10? (1=Poor, 10=Excellent) _____

6. How would you rate the appearance of your smile on a scale of 1-10? (1=Poor, 10=Excellent) _____

7. What, if anything, would you like to change about your smile?

- ☐ Whiteness
- ☐ Alignment or crowding
- ☐ Size of the teeth
- ☐ Shape of the teeth
- ☐ Spaces between the teeth
- ☐ Exposed gum tissue
- ☐ Night guard to prevent tooth grinding
- ☐ Other concern _____

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Health History / 1

Name (Please Print)	Home Phone	Business/ Cell

Address (City, State, Zip)	Marital Status

Occupation	Email	Date of Birth	Sex:

SocSec #	Emerg Contact/ Relationship	Home Phone	Cell Phone

If you are completing this form for another person:	Your Name	Relationship to Patient

As is 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. 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 to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information: *Please clearly mark the appropriate box*

Y	N		Y	N	
☐	☐	Do your gums bleed when you brush or floss?	☐	☐	Do you have any clicking, popping or discomfort in the jaw?
☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you clench or grind your teeth?
☐	☐	Is your mouth dry?	☐	☐	Do you have sores or ulcers in your mouth?
☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	Do you wear dentures, partials, retainers or occlusal guards?
☐	☐	Any problems associated with previous dental treatment?	☐	☐	Do you participate in active recreational activities?
☐	☐	Is your home water supply fluoridated?	☐	☐	Have you ever had a serious injury to your head or mouth?
☐	☐	Do you have earaches or neck pains?	☐	☐	Are you currently experiencing dental pain/discomfort?

If currently experiencing dental discomfort, please explain. _____

What is the reason for your visit today? _____

How do you feel about your smile? _____

Medical Information: *Please clearly mark the appropriate box*

Y	N	
☐	☐	Are you currently under the care of a physician?

Physician Name (Please Print)	Address		

Phone	Date of Last Exam	BP	Pulse

☐	☐	Are you in good health?
☐	☐	Has there been any change in your general health within the past year?

If yes, what condition is being treated? _____

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Health History / 2

Y N

☐ ☐ Do you have a preferred pharmacy? Please provide the name of the pharmacy, and phone number below.

_____

☐ ☐ Do you wear contact lenses?

☐ ☐ Have you had orthopedic total joint replacement (hip, knee, elbow, finger)?

☐ ☐ Are you scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for Osteoporosis or Paget's disease?

Y N

☐ ☐ Do you use controlled substances? (drugs?)

☐ ☐ Do you use tobacco? (smoking, snuff, chew, vaping)

☐ ☐ Do you use medical marijuana?

☐ ☐ Do you drink alcoholic beverages? If yes:

How much in the last 24 hrs? _____

How much in a week? _____

Heart Disease: *Please indicate if you have any of the following diseases or problems.*
PLEASE NOTE: Except for the following conditions, antibiotic prophylaxis is no longer recommended for any other form of Congenital Heart Disease (CHD).

Y N

☐ ☐ Do you have an artificial (prosthetic) heart valve?

☐ ☐ Do you have previous infective endocarditis?

☐ ☐ Do you have damaged valves in a transplanted heart?

Y N

☐ ☐ Do you have Congenital Heart Disease (CHD)?

☐ ☐ Unrepaired, cyanotic CHD?

☐ ☐ Repaired (completely) in the last 6 months?

☐ ☐ Repaired CHD with residual defects?

Medical History: *Please indicate if you have had any of the following diseases or problems.*

☐ Cardiovascular disease
☐ Angina
☐ Arteriosclerosis
☐ Congestive heart failure
☐ Damaged heart valves
☐ Heart attack
☐ Heart murmur
☐ Low blood pressure
☐ High blood pressure
☐ Congenital heart defects
☐ Mitral valve prolapsed
☐ Pacemaker
☐ Rheumatic fever
☐ Rheumatic heart disease
☐ Abnormal bleeding
☐ Anemia

☐ Hemophilia
☐ Blood transfusion
☐ If yes, date:
☐ AIDS or HIV infection
☐ Arthritis
☐ Rheumatoid arthritis
☐ Systemic lupus Erythematosus
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Sinus Trouble
☐ Tuberculosis
☐ Cancer / Chemotherapy / Radiation Treatment
☐ Chest pain upon exertion
☐ Chronic pain

☐ Diabetes Type I or II
☐ Eating Disorder
☐ Malnutrition
☐ Gastrointestinal disease
☐ G.E. Reflux
☐ Persistent heartburn
☐ Ulcers
☐ Thyroid problems
☐ Stroke
☐ Glaucoma
☐ Hepatitis, jaundice or liver disease
☐ Epilepsy
☐ Fainting spells/seizures
☐ Sleep Disorders
☐ Snoring

☐ Anxiety
☐ Depression
☐ ADHD/ADD
☐ Bipolar
☐ Schizophrenia
☐ Autism
☐ Dementia
☐ PTSD
☐ Kidney problems
☐ Night sweats
☐ Osteoporosis
☐ Persistent swollen glands in neck
☐ Severe headaches/migraines
☐ Severe or rapid weight loss
☐ Sexually transmitted disease
☐ Excessive Urination

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Health History / 3

Women Only: *Please mark the appropriate box*

Y N
☐ ☐ Pregnant? (Drugs?) How many weeks: _____
☐ ☐ Nursing?

Y N
☐ ☐ Taking birth control pills or hormonal replacement?

Medications: *Please list any prescription or over-the-counter medicines including vitamins, natural or herbal preparations and/or dietary supplements.*

Medicine / Supplement: _____ How much: _____ How often: _____
Medicine / Supplement: _____ How much: _____ How often: _____
Medicine / Supplement: _____ How much: _____ How often: _____
Medicine / Supplement: _____ How much: _____ How often: _____
Medicine / Supplement: _____ How much: _____ How often: _____
Medicine / Supplement: _____ How much: _____ How often: _____

Allergies: *Please indicate if you are allergic to or have you had a reaction to any of the following,* ***and list your specific type of reaction****.*

☐ Local Anesthetics _____
☐ Aspirin _____
☐ Penicillin/other antibiotics _____
☐ Barbiturates/sedatives/sleeping pills _____
☐ Sulfa drugs _____
☐ Codeine/other narcotics _____
☐ Metals _____
☐ Latex (rubber) _____
☐ Iodine _____
☐ Hay Fever / seasonal _____
☐ Animals _____
☐ Food _____
☐ Other _____
☐ Other _____

Surgical History: *Please list any operations or reasons that you've been hospitalized.*

Type: _____ Year: _____
Type: _____ Year: _____
Type: _____ Year: _____
Type: _____ Year: _____
Type: _____ Year: _____

Hospitalizations: _____

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Health History / 4

Y	N	
☐	☐	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, please provide name of the physician or dentist and their phone number: _____
☐	☐	Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above, and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

For completion by the dentist: _____