A Gentle Dental Center

Medical and Dental Questionnaire

Patient Name (Last, First, MI) _____

Date of Birth (MM/DD/YYYY) _____

Mark your response to indicate if you have had any of the following diseases or problems.

If you have a disease or problem that is not listed below, write the disease or condition in the space at the bottom of this form.

Date of last physical: _____ Physician: Name_____ Telephone _____

Are you pregnant? Yes ❑ No ❑ Address: _____

Yes	No		Yes	No		Yes	No	
❑	❑	Any changes in your health within the past year?	❑	❑	Immune Past use of steroids	❑	❑	Mental Health Bipolar disorder
			❑	❑	Delayed healing	❑	❑	Depression
						❑	❑	Anxiety
Yes	No	Cardiovascular	Yes	No	Musculoskeletal	❑	❑	Eating disorders
❑	❑	High blood pressure	❑	❑	Arthritis/ Osteoarthritis	❑	❑	Sleep disorder
❑	❑	Angina (chest pain)	❑	❑	Artificial joint	❑	❑	Dementia
❑	❑	Heart Attack	❑	❑	Fibromyalgia	❑	❑	ADHD / Autism
❑	❑	Irregular heart beat	❑	❑	Lupus			
❑	❑	Heart surgery	❑	❑	Sjogren's Syndrome	Yes	No	Infections
❑	❑	Heart failure	❑	❑	Osteoporosis	❑	❑	HIV positive/AIDS
❑	❑	Damaged heart valve				❑	❑	Sexually transmitted disease
❑	❑	High cholesterol	Yes	No	Gastrointestinal			
❑	❑	Heart infection	❑	❑	Acid reflux/ GERD	Yes	No	Allergies
❑	❑	Stroke	❑	❑	Irritable Bowel	❑	❑	Local anesthetic
			❑	❑	Stomach ulcer	❑	❑	Antibiotics
Yes	No	Hematologic				❑	❑	Aspirin/Ibuprofen
❑	❑	Anemia	Yes	No	Hepatic	❑	❑	Acetaminophen (Tylenol)
❑	❑	Sickle cell anemia	❑	❑	Liver disease	❑	❑	Codeine/narcotics
❑	❑	Abnormal bleeding	❑	❑	Jaundice	❑	❑	Metals
			❑	❑	Hepatitis	❑	❑	Latex
Yes	No	Respiratory				❑	❑	Other:
❑	❑	Asthma	Yes	No	Neurologic			
❑	❑	Emphysema/bronchitis	❑	❑	Epilepsy / seizures	Yes	No	Other
❑	❑	Sleep apnea	❑	❑	Parkinson's Disease	❑	❑	Cancer
❑	❑	Difficulty breathing	❑	❑	Multiple sclerosis	❑	❑	Cancer treatment
❑	❑	Tuberculosis	❑	❑	Headaches	❑	❑	Nursing infant
						❑	❑	Tobacco use
Yes	No	Endocrine	Yes	No	Skin	❑	❑	Alcohol use
❑	❑	Diabetes	❑	❑	Hives or skin rash	❑	❑	Chemical dependency
❑	❑	Thyroid Problem	❑	❑	Other skin lesions	❑	❑	Street/Recreational Drugs
						❑	❑	Vitamin Supplements
Yes	No	Renal	Yes	No	Eyes/Ears			
❑	❑	Kidney disorder	❑	❑	Glaucoma			
❑	❑	Dialysis	❑	❑	Impaired vision			
			❑	❑	Impaired hearing			

Please list any disease, condition, or problem you have that is not listed above.

_____

_____

Please list any hospitalizations or surgeries you have had.

_____

_____

Please explain if you answered "yes" to, or are uncertain about, any of the above items.

_____

_____

(Please continue on opposite side)

Dental Information

General Dental Health

Yes	No	
❑	❑	Is it important for you to keep your teeth?
❑	❑	Are you satisfied with the appearance of your teeth?
❑	❑	Are you satisfied with the function of your teeth?
❑	❑	Does food frequently get caught between teeth?
❑	❑	Do your gums often bleed while brushing?
❑	❑	Have you noticed loosening of your teeth?
❑	❑	Have you injured your head, neck, or jaw?
❑	❑	Do you have a dry mouth?
❑	❑	Have you had a change in your ability to taste foods?

Yes	No	TMJ - Have you noticed:
❑	❑	Clicking, popping or noise in the jaw?
❑	❑	Pain (joint, ear, side of face, cheeks)?
❑	❑	Difficulty opening or closing?
❑	❑	Difficulty chewing, talking or swallowing?
❑	❑	Does your jaw ever "catch" or "lock"?
❑	❑	Do you have frequent headaches?
❑	❑	Do you clench or grind your teeth?
❑	❑	Bite your lips. cheek or tongue frequently?
❑	❑	Have you ever had your bite adjusted?

Past Dental History

Yes	No	Have you had:
❑	❑	Orthodontic treatment (braces)?
❑	❑	Oral surgery? (wisdom teeth, other)
❑	❑	Periodontal (gum) disease treatment?
❑	❑	Root canal treatment?
❑	❑	TMJ therapy?
❑	❑	Oral Cancer?
❑	❑	A bite plane/nightguard or other appliance?
❑	❑	Sealants and regular fluoride treatments?

Current Conditions

Yes	No	Do you currently have:
❑	❑	Dental pain?
❑	❑	Sores or swelling of the mouth?
❑	❑	A partial/full denture or dental implants?
❑	❑	Have you had any difficulty with dental treatment?
❑	❑	Sensitivity to sweet, hot, cold, pressure?
❑	❑	Do you have well water?

1. Date of last dental x-rays:_____
2. Date of last dental treatment:_____
3. Date of last teeth cleaning:_____
4. How often do you brush your teeth?_____
5. How often do you floss?_____

Please explain if you answered "yes" to, or are uncertain about, any of the above items.

_____

_____

Please list any medication(s) you are taking:

_____

_____

To the best of my knowledge, the preceding information is complete and correct.

_____ _____

Signature - patient (or parent/guardian if patient is under 18) Date

Recorded by:_____

Medical Updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	PROVIDER INITIALS