

# Personal Dental Health Evaluation

Name (please print) \_\_\_\_\_ Date \_\_\_\_\_

1. When was your last dental visit? \_\_\_\_\_
2. How often did you see the dentist? \_\_\_\_\_
3. Do any of the following cause you discomfort?     Chewing     Hot     Cold     Sweets
4. How often do you...
  - Brush your teeth? \_\_\_\_\_
  - Floss? \_\_\_\_\_
  - Rinse/Mouth Wash? \_\_\_\_\_
5. Do your gums bleed while cleaning?     Yes     No
6. Do your gums feel tender or swollen?     Yes     No
7. Have you had periodontal gum treatment?     Yes     No
8. Do you clench or grind your teeth?     Yes     No
9. Do your jaws ever...     Feel tired or ache?     Click or pop?
10. Can you chew on both sides of your mouth comfortably?     Yes     No
11. Do you have frequent...
  - Headaches?     Yes     No
  - Earaches?     Yes     No
  - Neck and shoulder pain?     Yes     No
12. Have you ever had orthodontic treatment? (braces)     Yes     No
 

If Yes, when? \_\_\_\_\_
13. Do you usually have many cavities?     Yes     No
14. Do you have any loose teeth?     Yes     No
15. Do you have any noticeable wear on your teeth?     Yes     No
16. Do you have any food traps on your teeth?     Yes     No
17. Do you have any missing teeth?     Yes     No
  - Have they been replaced?     Yes     No
  - If so, how?
    - Fixed bridge
    - Removable partial
    - Full denture
    - Dental implant
18. Are you comfortable with the replacement?     Yes     No
 

If No, please describe: \_\_\_\_\_
19. Do you lose fillings or break fillings?     Yes     No
20. Do you have any cracked or broken teeth?     Yes     No
21. Have you ever had an unpleasant dental experience?     Yes     No



# Medical History

Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important relationship with the dentistry you receive. Thank you for answering the following questions.

Last	First	Middle	Date
Date of Birth: _____		Email: _____	
Name of Physician: _____		Phone Number: _____	
In Case of Emergency: _____		Phone Number: _____	

**Please Indicate If You've Had or Currently Have Any of the Following:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV               | <input type="checkbox"/> Frequent Headaches      | <input type="checkbox"/> Low Blood Pressure             |
| <input type="checkbox"/> Alzheimer's/Dementia   | <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Osteoporosis                   |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Pacemaker                      |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Hepatitis A, B, or C    | <input type="checkbox"/> Psychological Problems         |
| <input type="checkbox"/> Artificial Valve       | <input type="checkbox"/> Herpes Simplex Virus    | <input type="checkbox"/> Radiation/Chemotherapy         |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Recurrent Infections           |
| <input type="checkbox"/> Auto Immune Disease    | <input type="checkbox"/> Hyperthyroid            | <input type="checkbox"/> Respiratory Problems           |
| <input type="checkbox"/> Bleeding Problems      | <input type="checkbox"/> Hypothyroid             | <input type="checkbox"/> Seizures                       |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Inflammatory Rheumatism | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Other Serious Illnesses: _____ |
| <input type="checkbox"/> Drug/Alcohol Treatment | <input type="checkbox"/> Liver Problems          | _____   |

**Have You Ever Had Any Unusual Reactions/Allergies to the Following Drugs:**

- |  |                                       |                                       |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Acetaminophen     | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sulfa        |
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Ibuprofen    | <input type="checkbox"/> Sulfites     |
| <input type="checkbox"/> Codeine           | <input type="checkbox"/> Latex        | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dental Anesthetic | <input type="checkbox"/> Penicillin   | _____                                 |

**List All Medications You Are Taking: (including over the counter drugs, herbals and vitamins)**

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____
7. _____	8. _____	9. _____

**Do you use tobacco?**  Yes (type: \_\_\_\_\_)  No

**Women:** Are you...  Pregnant  Nursing

Do you have any special instructions from a physician regarding pre-medication for dental work? \_\_\_\_\_

Is there anything regarding your health that would be important for us to know before starting treatment? \_\_\_\_\_

*To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.*

**Signature of Patient or Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

\*\*I authorize the use of my (or patient's) study models and/or photographs for lectures or publications by Lowell W. Hanson, DDS \_\_\_\_\_ (INITIAL)