DENTAL HISTORY

Referred by__________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist __________________ How long have you been a patient?__________Months/Years

Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______

Date of most recent treatment (other than a cleaning) ______/______/______ Year of most recent cleaning__________

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? * __________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY — YES / NO

1. Are you fearful or anxious of dental treatment? How much, on a scale of 1 (least) to 10 (most) [ ] __________ ☐ ☐
2. Have you had an unfavorable dental experience or complications with treatment? __________ ☐ ☐
3. Have you ever had trouble getting numb or had any reactions to local anesthetic? * __________ ☐ ☐
4. Did you ever have braces, orthodontic treatment or had your bite adjusted? __________ ☐ ☐

SMILE CHARACTERISTICS — YES / NO

5. Is there anything about the appearance of your teeth that you would like to change?__________ ☐ ☐
6. Do you ever wish you had a whiter smile? __________ ☐ ☐
7. Have you felt uncomfortable or self conscious about the appearance of your teeth? __________ ☐ ☐
9. Have you been disappointed with the appearance of previous dental work? __________ ☐ ☐

BITE AND JAW JOINT — YES / NO

10. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping, ear ringing)__________ ☐ ☐
11. Do you / would you have any problems chewing gum or any hard food? __________ ☐ ☐
12. Have your teeth changed in the last 5 years, become shorter, thinner or worn? __________ ☐ ☐
13. Are your teeth crowding or developing spaces? __________ ☐ ☐
14. Do you have more than one bite and squeeze to make your teeth fit together? __________ ☐ ☐
15. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? __________ ☐ ☐
16. Do you clench your teeth in the daytime or make them sore or grind them at night? __________ ☐ ☐
17. Do you wear or have you ever worn a bite appliance?__________ ☐ ☐

TOOTH STRUCTURE — YES / NO

18. Have you had any cavities within the past 3 years?__________ ☐ ☐
19. Does the amount of saliva in your mouth seem too little? __________ ☐ ☐
20. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?__________ ☐ ☐
21. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?__________ ☐ ☐
22. Do you have grooves or notches on your teeth near the gum line? __________ ☐ ☐
23. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? __________ ☐ ☐
24. Do you get food caught between any teeth? __________ ☐ ☐

GUM AND BONE — YES / NO

25. Do your gums ever bleed when brushing or flossing? __________ ☐ ☐
26. Have you ever been treated for gum disease or been told you have lost bone around your teeth? __________ ☐ ☐
27. Have you ever noticed an unpleasant taste or odor in your mouth, or been told that you do? __________ ☐ ☐
28. Is there anyone with a history of periodontal or gum disease in your family? __________ ☐ ☐
29. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?__________ ☐ ☐
30. Have you experienced a burning sensation in your mouth?__________ ☐ ☐

Patient's Signature * __________________ Date__________

Doctor's Signature __________________ Date __________

*forms completed digitally will be signed in person when you arrive at our office.

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ________

Name of Physician/and their specialty ______________________

Most recent physical examination ______________ Purpose ______________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES / NO

1. hospitalization for illness or injury ______ ☐ ☐
2. an allergic reaction to
   - ☐ None, I have no allergies, None
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulpha
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ metals (nickel, gold, silver, ________)
   - ☐ latex
   - ☐ other ______

YES / NO

3. heart problems, or cardiac stent within the last six months ______ ☐ ☐
4. history of infective endocarditis, bacterial ______ ☐ ☐
5. artificial heart valve, repaired heart defect (PFO) ______ ☐ ☐
6. pacemaker or implantable defibrillator ______ ☐ ☐
7. artificial prosthesis (joints) ______ ☐ ☐
8. rheumatic or scarlet fever ______ ☐ ☐
9. high or low blood pressure ______ ☐ ☐
10. a stroke (taking blood thinners) ______ ☐ ☐
11. prolonged bleeding due to a slight cut (INR > 3.5) ______ ☐ ☐
12. emphysema, sarcoidosis, COPD ______ ☐ ☐
13. tuberculosis ______ ☐ ☐
14. asthma ______ ☐ ☐
15. breathing or sleep problems (i.e. snoring, sinus) ______ ☐ ☐
16. kidney disease ______ ☐ ☐
17. liver disease ______ ☐ ☐
18. thyroid, parathyroid disease, or calcium deficiency ______ ☐ ☐
19. hormone deficiency ______ ☐ ☐
20. high cholesterol or taking statin drugs ______ ☐ ☐
21. diabetes (HbA1c = ______) ______ ☐ ☐
22. stomach or duodenal ulcer ______ ☐ ☐
23. digestive disorders (i.e. gastric reflux) ______ ☐ ☐

YES / NO

24. osteoporosis/osteopenia (i.e. taking bisphosphonates) ______ ☐ ☐
25. arthritis ______ ☐ ☐
26. glaucoma ______ ☐ ☐
27. head or neck injuries ______ ☐ ☐
28. epilepsy, convulsions (seizures) ______ ☐ ☐
29. neurologic problems (attention deficit disorder) ______ ☐ ☐
30. viral infections and cold sores ______ ☐ ☐
31. any lumps or swelling in the mouth ______ ☐ ☐
32. venereal disease ______ ☐ ☐
33. hepatitis (type ___) ______ ☐ ☐
34. HIV / AIDS ______ ☐ ☐
35. tumor, abnormal growth ______ ☐ ☐
36. radiation therapy ______ ☐ ☐
37. chemotherapy ______ ☐ ☐
38. emotional problems ______ ☐ ☐
39. psychiatric treatment ______ ☐ ☐
40. antidepressant medication ______ ☐ ☐
41. alcohol / drug dependency ______ ☐ ☐
42. COVID-19 positive ______ ☐ ☐

ARE YOU:

43. presently being treated for any other illness ______ ☐ ☐
44. aware of a change in your general health ______ ☐ ☐
45. taking medication for weight management (i.e. fen-phen) ☐ ☐
46. taking dietary supplements ______ ☐ ☐
47. subject to frequent headaches ______ ☐ ☐
48. a smoker or smoked previously ______ ☐ ☐
49. FEMALE - taking birth control pills ______ ☐ ☐
50. FEMALE - pregnant ______ ☐ ☐
51. MALE - prostate disorders ______ ☐ ☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

____

List all medications, supplements, and or vitamins you are currently taking.

Drug	Purpose	Drug	Purpose

Patient's Signature * ______________________ Date ________

Doctor's Signature ______________________ Date ________

Updated History ______________ Date ________ Updated History ______________ Date ________

Updated History ______________ Date ________ Updated History ______________ Date ________

*forms completed digitally will be signed in person when you arrive at our office.

Scott A Young DDS (e) scottayoungdds@gmail.com (w) 704-541-5900 (f) 704-541-5454