CRYSTAL RIVER DENTAL

DENTAL HISTORY

Last Dental Treatment_____ Last Dental X-rays_____
Previous Dentist_____ How long with this dentist_____
How often are your teeth cleaned?_____

Please answer by circling YES or NO to the following:

YES NO Is there anything you would like to change about the look or feel of your teeth?
YES NO Dental fears or unfavorable experiences?
YES NO Problems with effectiveness or bad reactions to dental anesthetics?
YES NO Orthodontic treatment? (Date_____)
YES NO Periodontal (gum) treatment?
YES NO Avoid brushing any part of your mouth?
YES NO Have gums that bleed when brushing or flossing?
YES NO Have teeth that are sensitive to hot or cold?
YES NO Have sore or painful teeth?
YES NO Have a burning sensation in your mouth?
YES NO Have difficulty swallowing?
YES NO Have an unpleasant taste or odor in your mouth?
YES NO Dry mouth, throat, and/or eyes?
YES NO Jaw problems (temporomandibular joint)?
YES NO Difficulty in opening your mouth widely?
YES NO Stiff neck muscles?
YES NO Awaken with an awareness of your teeth or jaw?
YES NO Have tension headaches?
YES NO Clench or grind your teeth?
YES NO Lost any teeth?
YES NO Wear a bite splint, night guard, orthodontic retainer, or sleep apnea appliance?
YES NO Sores or growths in your mouth?
YES NO Loose teeth or broken fillings?
YES NO Food collection between teeth?

How often do you brush?_____
How often do you floss?_____

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a removable partial or complete denture, please complete the following:

YES NO Has your present denture been relined? When?_____

YES NO Is your present denture a problem? Describe_____
_____
_____
_____

YES NO Are you satisfied with the appearance?

YES NO Are you satisfied with the comfort?

When did you receive your first partial or complete denture?_____

How long have you worn your present denture?_____

Patient Signature (parent/guardian)_____ **Date**_____
Doctor's Signature_____ **Date**_____
*Reviewed*_____ *Date*_____
*Reviewed*_____ *Date*_____

CRYSTAL RIVER DENTAL

PATIENT NAME_____ BIRTH DATE_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Heart Pacemaker
- ❑ Congenital Heart Problems
- ❑ Artificial heart valve
- ❑ Artificial joint
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Stroke
- ❑ Lung or breathing problems
- ❑ Hepatitis/Jaundice/or other liver disease
- ❑ Blood transfusion
- ❑ Diabetes (insulin/diet controlled)
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hay fever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Multiple Sclerosis
- ❑ Neuro-muscular disease
- ❑ Kidney disease
- ❑ Thyroid or parathyroid problems
- ❑ Ulcers
- ❑ Digestive disorders/ acid reflux
- ❑ Arthritis/Rheumatism
- ❑ Glaucoma
- ❑ Head or neck injuries
- ❑ Sexually transmitted disease
- ❑ Chemotherapy
- ❑ Radiation therapy
- ❑ Emotional problems
- ❑ Psychiatric treatment
- ❑ Alcohol/drug dependency
- ❑ Sleep Apnea
- ❑ Osteoporosis or bone disorders
- ❑ Hearing problems

Do you smoke or use chewing tobacco? ❑ Yes ❑ No

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Tetracycline
- ❑ Aspirin or Ibuprofen
- ❑ Nut Allergy
- ❑ Other: _____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Please list all other Medications:_____

_____
_____
_____
_____
_____
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_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician: _____

Do you have any disease or condition not listed above?_____

Have you ever tested positive for COVID-19 or suspected you may have it?_____

Please add anything else you would like us to know about: _____

Have you been hospitalized in the last 5 years? Please explain: _____