Oral and Systemic Health History

Name:_____ Today's Date _____

Signature:_____ What is your most important concern today?_____

Caries (tooth decay): Do you consider yourself cavity prone?.....Y N Do you consume sugary foods or beverages on a regular basis?..... Y N Does your mouth feel dry? ..... Y N Do you have heartburn or reflux..... Y N	**Pharmacology**: List all medications you're currently taking, including prescription and OTC meds, vitamins and supplements: Do you have a desire to reduce the amount of medication you currently take?.....Y N
Periodontal Disease: Have you been told you have gingivitis or gum disease in the past?..... Y N Do your gums ever bleed when you brush or floss? ..... Y N Do you have gum recession or exposed root surfaces?..... Y N Do you have any loose teeth, drifting teeth, or areas that collect food when you eat?..... Y N Do you smoke or chew tobacco? …….. Y N	**Sleep:** Do you or your bed partner: Ever snore? .....Y N Experience interruptions in breathing during sleep?.....Y N Have difficulty sleeping?.....Y N Wake up often to use the restroom?.....Y N Feel tired or fatigued during the day?.....Y N Have a sleep study history? .....Y N Have a CPAP or oral sleep appliance.....Y N
Function/Bite/TMJ dysfunction: Do you have any missing teeth other than wisdom teeth? ..... Y N Do you experience discomfort when chewing? ...Y N Do your jaw joints click, pop or make grinding sounds? .....Y N Do you experience frequent headaches or jaw/facial pain?.....Y N Do your joints ever get stuck or locked?.....Y N Have you ever been treated for a jaw joint problem?.....Y N	**Allergies:** Are you aware of any chronic inflammatory conditions such as irritable bowel syndrome, fibromyalgia, arthritis, chronic fatigue syndrome, insulin resistance, or periodontal/gum disease?.....Y N Are you aware of any allergies? .....Y N If so, please list:

Physician Information:

Are you currently under the care of a physician? If so, for what?_____

Date of last Medical Check up:_____

Does your physician require you to take special medication before dentistry? _____

_____

Your Physician's name (above) Address Phone