Dentistry on Bayview
Family Dentistry

DENTAL HISTORY FORM

PATIENT

DATE * : _____

First Name* : _____ Last Name * : _____

I prefer to be called : _____

Birth date * : _____ Sex * : ☐ Male ☐ Female

Home Address * : _____ City, Province, Postal Code * : _____

Home Phone * : _____ Cell Phone * : _____ Work Phone * : _____

Email * : _____

EMERGENCY CONTACT

Emergency Contact Name : _____ Relationship to patient : _____

Address (if different than patient address) : _____

Home Phone * : _____ Cell Phone * : _____ Work Phone * : _____

DENTAL HISTORY

Last Dentist Name(leave blank if unknown, or no dentist): _____

Address, City, State : _____ Last seen : _____ Reason : _____

Other dentists/dental specialists now being seen : _____ City, Province: _____

Reason : _____

PHYSICIAN

Patient's Physician : _____ Address, City, Province : _____

Last seen : _____ Reason : _____ Next Appointment : _____

Most recent physical exam : _____

OTHER PHYSICIANS/HEALTH CARE PROVIDERS BEING SEEN NOW

Name* : _____ City, Province* : _____

Reason : _____

Name* : _____ City, Province* : _____

Reason : _____

GENERAL INFORMATION

What concerns you about your teeth? : _____

DENTAL HISTORY

Now or in the past, have you had Permanent or extra (supernumerary) teeth removed?
☐ Yes ☐ No ☐ Don't know

Chipped or injured primary or permanent teeth?
☐ Yes ☐ No ☐ Don't know

Bleeding gums, bad taste or mouth odor?
☐ Yes ☐ No ☐ Don't know

Any teeth treated with root canals or pulpotomies?
☐ Yes ☐ No ☐ Don't know

History of speech problems or speech therapy?
☐ Yes ☐ No ☐ Don't know

Food impaction between the teeth?
☐ Yes ☐ No ☐ Don't know

History of speech problems?
☐ Yes ☐ No ☐ Don't know

Teeth causing irritation to lip, cheek or gums?
☐ Yes ☐ No ☐ Don't know

Tooth grinding or clenching?
☐ Yes ☐ No ☐ Don't know

Soreness in jaw muscles or face muscles?
☐ Yes ☐ No ☐ Don't know

Have you ever been treated for "TMJ" or "TMD" problems?
☐ Yes ☐ No ☐ Don't know

Any serious trouble associate with previous dental treatment?
☐ Yes ☐ No ☐ Don't know

Have you ever had an orthodontic consultation or treatment before now?
☐ Yes ☐ No ☐ Don't know

Supernumerary (extra) or congenitally missing teeth?
☐ Yes ☐ No ☐ Don't know

Any sensitive or sore teeth?
☐ Yes ☐ No ☐ Don't know

Jaw fractures, cysts, infections?
☐ Yes ☐ No ☐ Don't know

"Gum boils," frequent canker sores or cold sores?
☐ Yes ☐ No ☐ Don't know

Difficulty breathing through nose?
☐ Yes ☐ No ☐ Don't know

Mouth breathing habit or snoring at night?
☐ Yes ☐ No ☐ Don't know

Frequent oral habits (sucking finger, chewing pen, etc.)?
☐ Yes ☐ No ☐ Don't know

Abnormal swallowing (tongue thrust)?
☐ Yes ☐ No ☐ Don't know

Clicking, locking in jaw joints?
☐ Yes ☐ No ☐ Don't know

Ringing in ears, difficulty in chewing or opening jaw?
☐ Yes ☐ No ☐ Don't know

Any broken or missing fillings?
☐ Yes ☐ No ☐ Don't know

Have you ever been diagnosed with gum disease or pyorrhea?
☐ Yes ☐ No ☐ Don't know

HAVE YOU HAD ALLERGIES OR REACTIONS TO ANY OF THE FOLLOWING:

Local anesthetics (novocaine, lidocaine, xylocaine)
☐ Yes ☐ No ☐ Don't know

Aspirin
☐ Yes ☐ No ☐ Don't know

Penicillin
☐ Yes ☐ No ☐ Don't know

Metals (jewelry, clothing snaps)
☐ Yes ☐ No ☐ Don't know

Plant pollens
☐ Yes ☐ No ☐ Don't know

Foods
☐ Yes ☐ No ☐ Don't know

Latex (gloves, balloons)
☐ Yes ☐ No ☐ Don't know

Ibuprofen (Motrin, Advil)
☐ Yes ☐ No ☐ Don't know

Other antibiotics
☐ Yes ☐ No ☐ Don't know

Acrylics
☐ Yes ☐ No ☐ Don't know

Animals
☐ Yes ☐ No ☐ Don't know

Other substances
☐ Yes ☐ No ☐ Don't know

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication :	Taken for :

Have you ever taken any medications to strengthen your bones? Please describe. :

Do you take antibiotic pre-medication before any dental procedures?

☐ Yes ☐ No

Do you or have you ever had a substance abuse problem? _____

Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____

How often do you floss? _____

Women: Are you pregnant?

☐ Yes ☐ No

Are you trying to become pregnant?

☐ Yes ☐ No