DR. IAN GRAY
A Balance for Dentistry and Health

Dr. Ian Gray, DDS

DENTAL HISTORY

PATIENT INFORMATION (Confidential)

Name _____Nickname_____Age_____

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) _____/_____/_____

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

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PATIENT HISTORY

	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least)t o 10 {most) _____	☐	☐
2. Have you had an unfavorable dental experience?_____	☐	☐
3. Have you ever had complications from past dental treatment?_____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?_____	☐	☐
6. Have you had any teeth removed?_____	☐	☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change?_____	☐	☐
8. Have you ever whitened (bleached) your teeth?_____	☐	☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth?_____	☐	☐
10. Have you been disappointed with the appearance of previous dental work?_____	☐	☐

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____	☐	☐
12. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
14. Are your teeth crowding or developing spaces? _____	☐	☐
17. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?_____	☐	☐
19. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ___	☐	☐
20. Do you clench your teeth in the daytime or make them sore? _____	☐	☐
21. Do you have any problems with sleep or wake up with an awareness of your teeth?_____	☐	☐
22. Do you wear or have you ever worn a bite appliance?_____	☐	☐

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
TOOTH STRUCTURE		
23. Have you had any cavities within the past 3 years?	☐	☐
24. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
25. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
26. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
27. Do you have grooves or notches on your teeth near the gum line?	☐	☐
28. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
29. Do you frequently get food caught between any teeth?	☐	☐
GUM AND BONE		
30. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
31. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
32. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
33. Is there anyone with a history of periodontal disease in your family?	☐	☐
34. Have you ever experienced gum recession?	☐	☐
35. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
36. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

PATIENT INFORMATION (Confidential)

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

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine ☐ penicillin ☐ erythromycin ☐ tetracyciine ☐ sulfa ☐ local anesthetic ☐ fluoride ☐ meta:s (nickel, go!d, silver ☐ !atex ☐ other		
3. heart problems, or cardiac stent within the last six months_____	☐	☐
4. history of infective endocaraitis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO} _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis(heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other biood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems(i.e. snoring,sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22 high cholesterol or taking statin drugs _____	☐	☐

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
23. diabetes (HbA1c=)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive isorders (i.e. gastric reflux)	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27. arthritis	☐	☐
28. glaucoma	☐	☐
29. contact lenses	☐	☐
30. head or neck injuries	☐	☐
31. epilepsy, convulsions (seizures)	☐	☐
32. neurologic problems (attention deficit disorder)	☐	☐
33. viral infections and cold sores	☐	☐
34. any lumps or swelling in the mouth	☐	☐
35. hives, skin rash, hay fever	☐	☐
36. venereal disease	☐	☐
37. hepatitis(type_)	☐	☐
38. HIV/ AIDS	☐	☐
39. tumor, abnormal growth	☐	☐
40. radiation therapy	☐	☐
41. chemotherapy	☐	☐
42. emotional problems	☐	☐
43. psychiatric treatment	☐	☐
44. antidepressant medication	☐	☐
45. alcohol/street drug use	☐	☐

ARE YOU:

46. presently being treated for any other illness	☐	☐
47. aware of a change in your health (i.e. fever, new cough)	☐	☐
48. taking medication for weight management (i.e.fen-phen)	☐	☐
49. taking dietary supplements	☐	☐
50. often exhausted or fatigued	☐	☐
51. experiencing frequent headaches	☐	☐
52. a smoker, smoked previously or use smokeless tobacco	☐	☐
53. considered a touchy person	☐	☐
54. often unhappy or depressed	☐	☐
55. FEMALE - taking birth control pills	☐	☐
56. FEMALE - pregnant	☐	☐
57. MALE- prostate disorders	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment (i.e. Botox, Col!agen Injection)

_____

List all medications, supplements, and /or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature_____ Date _____

Doctor's Signature_____ Date _____