Colorado Center for Dental Excellence

MEDICAL HISTORY

Patient name: _____

BP

Have you been under the care of a medical doctor during the past 2 years? Yes/No
If yes, for what? _____

Physicians Name_____ Phone_____
Are you currently taking any medication, drugs, or pills? Yes/No
If yes, list name and dosage _____
Are you aware of any allergies to medication or substances? Yes/No
If yes, please list. _____
Have you been hospitalized in the past 5 years? Yes/No
Have you had any skin reaction to jewelry or other metals? Yes/No
Have you had surgery, radiation, or chemotherapy treatment? Yes/No
Do you smoke cigarettes or use smokeless tobacco? Yes/No
How Long? _____ How much per day? _____
Do you drink alcoholic beverages? Yes/No
How much per week? _____
Have you taken the diet drugs Fen-Phen or Redux? Yes/No
Do you have any other disease, condition, or medical problem not listed above? Yes/No
If yes, please list. _____
Have you been told by a physician you need to take antibiotics prior to dental treatment? Yes/No
Women are you: pregnant? Yes/no month ____ Nursing? Yes/no taking birth control pills? Yes/no

*** Place an "X" next to the items below below that you either have or have had.**

☐ Heart (surgery, disease, Attack)	☐ Latex Allergy
☐ Congenital Heart Disease	☐ Diabetes
☐ Heart Murmur	☐ Chest Pain
☐ High Blood Pressure	☐ Bruise Easily
☐ Mitral Valve Prolapse	☐ Lung Problems
☐ Artificial Joints	☐ Stroke
☐ Allergies or Hives	☐ Pace Maker
☐ Rheumatic Fever	☐ Anemia
☐ Artificial Heart Valve	☐ Emphysema
☐ Drug/Alcohol Addiction	☐ Tuberculosis
☐ Sensitivity to Anesthetics	☐ Asthma
☐ Swollen Ankles	☐ Sinus Trouble
☐ Sexually Transmitted Diseases	☐ Bulimia
☐ Stomach/Digestive Problems	☐ Ulcers
☐ Excessive Bleeding/Hemophelia	☐ Glaucoma
☐ Epilepsy/Seizures	☐ Contact Lenses
☐ Hepatitis: Type_____	☐ HIV/AIDS
☐ Liver Disease	☐ Sickle cell Disease
☐ Arthritis/Rheumatism	☐ Nervous/Anxious
☐ Tumors/Cancers	☐ Thyroid Problems
☐ Psychiatric Care	☐ Fainting/Dizzy Spells
☐ Blood Transfusion	☐ Kidney Problems
☐ Diet (Special/Restricted)	☐ Acid Reflux

DENTAL HISTORY

What is the reason for your visit today? _____
When was the last time you saw a dentist? _____
What was done at that time?_____
Have you ever had an unpleasant dental experience? Yes/No
explain: _____
How often do you brush your teeth? _____
Do you use dental floss, tape, H2O pik? _____ How often?_____
What type of toothbrush do you use? Soft Medium Hard Electric
What other cleaning aids, devices, or rinses do you use? _____
How did you hear about our office? _____
Please list any questions or concerns you may have about your mouth or oral health:
_____
_____

*** Place an "X" next to the items below that you experience.**

- ☐ Tingling or burning tongue/ lips
- ☐ Bad breath/unpleasant taste
- ☐ Bleeding or sore gums
- ☐ food trapping between teeth
- ☐ Frequent headaches
- ☐ Clicking/popping jaw
- ☐ Swelling or lumps in mouth
- ☐ Sores in or around mouth
- ☐ Loose teeth
- ☐ Sensitive to hot
- ☐ Sensitive to cold
- ☐ Frequent dry mouth
- ☐ Sensitive to sweets
- ☐ Jaw pain
- ☐ Grinding/clenching
- ☐ Mouth breather
- ☐ treated for perio (gum disease)
- ☐ orthodontic treatment (braces)
- ☐ snoring
- ☐ Nervousness due to dental treatment

I understand the above information is necessary to provide me with dental in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/ Guardian Signature _____ **Date** _____

Doctor's Signature _____ **Date** _____

Smile Evaluation

Are you pleased with your smile? **VERY SORT-OF NOT AT ALL**
Are you with pleased with the color of your teeth? **VERY SORT OF NOT AT ALL**
Are you pleased with the shape of your teeth? **VERY SORT OF NOT AT ALL**
Are there spaces between your teeth that you don't like? **YES** or **NO**
Are there old fillings or dental treatment that you aren't happy with? **YES** or **NO**
Do you see too much gum when you smile? **YES** or **NO**
If you could change anything about your smile, what would it be?
_____
On the diagram to the right, please place an "X" on the areas you would like to improve / enhance with Botox/Juvederm. If you are unsure what Botox and Juvederm are, would you like for us to give you more information? **YES** or **NO**