Associates for General Dentistry, Ltd.
1307 N. Rand Road
Arlington Heights, IL 60004

AssociatesForGeneralDentistry.com

(847)392-4422

afgd1307@gmail.com

Dental History

Name:

*

Date of Birth:

*

What is the reason for your visit today?

*

Date of Last Dental Visit:

*

Last Dental Cleaning

*

Last set of X-rays

*

What was done at your last dental visit?

* ◯ Cleaning ◯ General Check up ◯ Problem Focused

If problem focused, please describe:

Previous Dentist's Name:

Previous Dentist's Phone Number:

Information needed to gather previous x-rays, notes, etc.

How often do you have dental exams?

* ◯ Never ◯ Once a year
◯ Twice a year ◯ Everytime I get my teeth cleaned
◯ When I think I need it ◯ Randomly

How often do you brush your teeth?

* ◯ Once a day ◯ Twice a day ◯ More than twice a day
◯ When I have time ◯ Not too sure

How often do you floss?

* ◯ Once a day ◯ Twice a day ◯ More than twice a day
◯ When I have time

Have you ever used or are currently using topical fluoride?

* ◯ Yes ◯ No

Do you have any dental problems now?

* ◯ Yes ◯ No

If yes, please describe:

Check all that apply:

* ☐ Sensitive to hot or cold ☐ Sensitive with sweets
☐ Pain while biting or chewing ☐ Gums bleed
☐ Gums hurt ☐ Bad tastes in my mouth
☐ Bad odor in my mouth ☐ Loose teeth
☐ Change in my bite ☐ Parents had gum disease
☐ Parents experienced tooth loss ☐ Clench/grind my teeth
☐ Bite my cheek/lip regularly ☐ Hold objects between my teeth (pens..)
☐ Breathe with my mouth open ☐ Jaw tires easily
☐ Snore ☐ Diagnosed with sleep disorder
☐ Smoke/chew tobacco ☐ None

Check all that apply, if you have ever had:

* ☐ Orthodontic treatment
☐ Oral surgery
☐ Periodontal treatment
☐ Bite adjustment
☐ Mouth guard/Night guard
☐ Clicking/popping of jaw
☐ Head/Neck or Shoulder aches
☐ Difficulty chewing
☐ Difficulty opening/closing mouth
☐ None

If food gets stuck between your teeth, where?

Are you satisfied with your teeth's appearance?

* ◯ Yes ◯ No

Have you ever had a serious injury to the mouth or head?

* ◯ Yes ◯ No

If yes, please describe:

Do you feel nervous about having dental treatment?

* ◯ Yes ◯ No

If yes, what is your biggest concern?

Have you ever had an upsetting dental experience?

* ◯ Yes ◯ No

If yes, please describe:

Is there anything else about having dental treatment that you would like us to know?

* ◯ Yes ◯ No

If yes, please describe:

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Medical History

Name:

Date of Birth:

Physician's Name:

Physician's Phone #

Have you had any medical care within the last two years, or have you been a patient in the hospital during the past 5 years?

* ◯ Yes ◯ No

If yes, please describe:

Are you currently taking, or have taken in the last two years, any medication, drugs, pills, or herbal remedies, including regular dosages of aspirin?

* ◯ Yes ◯ No

If yes, please describe:

Have you ever taken one of these medications for bone loss?

* ◯ Fosamax ◯ Actonel ◯ Boniva
◯ any bishosphonates ◯ no, I never have

Are you aware of having an allergic (or adverse) reaction to any substance or medication?

* ◯ Yes ◯ No

If yes, please specify:

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Please indicate which of the following you have, or have had in the past.

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Anemia
- [ ] Arthritis/Rheumatism
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Tranfusion
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Chest Pain
- [ ] Chronic Cough
- [ ] Clotting
- [ ] Cold Sores/Blisters
- [ ] Cong. Heart Disease
- [ ] Contact Lenses
- [ ] Cortisone Medicine
- [ ] Crohns disease
- [ ] Diabetes
- [ ] Diet (restricted)
- [ ] Dizziness
- [ ] Emphysema/COPD
- [ ] Epilepsy or Seizures
- [ ] Excessive Bleeding
- [ ] Fainting /Dizziness
- [ ] Glaucoma
- [ ] H.I.V./A.I.D.S.
- [ ] Hay Fever/Hives
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Kidney Disease
- [ ] Latex Sensitivity
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] MS
- [ ] MVP
- [ ] Nervous/Anxious
- [ ] Neuro Disorder
- [ ] Other
- [ ] Pacemaker/AHV
- [ ] Parkinsons Disease
- [ ] Pregnant (Currently)
- [ ] Psychiatric Care
- [ ] Radiation Therapy
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Sickle Cell Disease
- [ ] Sinus Problems
- [ ] Skin cancer
- [ ] Smoker
- [ ] Stroke
- [ ] Swollen Ankles
- [ ] Synthroid
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Weight Issues

If you have or have had any disease, condition, or problem not listed, please list:

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Do you have any questions for the doctor at this point in time?

* ◯ Yes ◯ No

If so, please comment below:

* ☐ I understand the above information is necessary to provide me with dental care 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 healthcare provider or agency, whom may release such information to you. I will notify the doctor of any change in my health or medication.

Signature: _____

Date: *

Response Date: