MEDICAL HISTORY

Patient Name ______________________ Preferred Name ______________ DOB ____________

Name of Physician/and their specialty ______________________________________

Most recent physical examination ________________ Purpose ______________________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. an allergic or bad reaction to any of the following:

Item	YES	NO
• aspirin, ibuprofen, acetaminophen, codeine	☐	☐
• erythromycin	☐	☐
• sulfa	☐	☐
• fluoride	☐	☐
• iodine	☐	☐
• latex	☐	☐
• fruit	☐	☐
• metals (nickel, gold, silver, __________)	☐	☐
penicillin	☐	☐
tetracycline	☐	☐
local anesthetic	☐	☐
chlorhexidine (CHX)	☐	☐
red dye	☐	☐
nuts	☐	☐
milk	☐	☐
other	☐	☐

Condition	YES	NO
2. hospitalization for illness or injury	☐	☐
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)	☐	☐
6. pacemaker or implantable defibrillator	☐	☐
7. orthopedic or soft tissue implant (joint replacement breast implants)	☐	☐
8. heart murmur, rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10. a stroke (taking blood thinners)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5)	☐	☐
13. pneumonia, emphysema, shortness of breath sarcoidosis	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox	☐	☐
15. breathing problems (asthma, nasal breathing, stuffy nose, sinus congestion)	☐	☐
16. sleep problems (sleep apnea, snoring, insomnia, restless sleep, bedwetting)	☐	☐
17. kidney disease	☐	☐
18. liver disease or jaundice	☐	☐
19. vertigo ("the room is spinning)	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency or imbalance (polycystic ovarian syndrome)	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. digestive or disorders (acid reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease)	☐	☐
25. stomach duodenal ulcer	☐	☐
25. diabetes (HbA1c=_______)	☐	☐
26. osteoporosis/osteopenia or ever taken antiresorptive medications (bisphosphonates)	☐	☐
27. arthritis or gout	☐	☐
28. autoimmune disease (rheumatoid arthritis lupus, scleroderma)	☐	☐
29. glaucoma	☐	☐
30. head or neck injuries	☐	☐
31. epilepsy, convulsions (seizures)	☐	☐
32. neurologic disorders (Alzheimer's disease, dementia, prion disease)	☐	☐
33. viral infections (cold sores) bacterial infections (Lyme disease)	☐	☐
34. any lumps or swelling in the mouth	☐	☐
35. hives, skin rash, hay fever	☐	☐
36. STI/STD/HPV	☐	☐
37. hepatitis (type________)	☐	☐
38. HIV/AIDS	☐	☐
39. tumor, abnormal growth	☐	☐
40. radiation therapy	☐	☐
41. chemotherapy, immunosuppressive medication	☐	☐
42. difficulties with stress management	☐	☐
43. psychiatric treatment, antidepressants, mood stabilizing medications	☐	☐
44. concentration problems or ADD/ADHD		
45. alcohol/recreational drug use	☐	☐

medical history continued

ARE YOU:	YES	NO
1. presently being treated for any other illness	☐	☐
2. aware of a change in your health in the last 24 hours (fever, chills, new cough, or diarrhea)	☐	☐
3. taking medication for weight management	☐	☐
4. taking dietary supplements, vitamins, and/or probiotics	☐	☐
5. often exhausted or fatigued	☐	☐
6. experiencing frequent headaches or chronic pain	☐	☐
7. a smoker, smoked previously or other (smokeless tobacco, vaping, e-cigarettes, or cannabis)	☐	☐
8. often unhappy or depressed	☐	☐
9. taking birth control pills	☐	☐
10. currently pregnant	☐	☐
11. diagnosed with prostate disorder	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

____

____

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

Drug	Purpose	Drug	Purpose

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 __________

© 2024 Kois Center, LLC

DENTAL HISTORY

Patient Name ______________________________ Preferred Name ______________ DOB ____/____/____

How often do you have dental cleanings? ☐ 3mo ☐ 4mo ☐ 6mo ☐ 12mo ☐ Not routinely

Date of most recent dental exam ____/____/____ dental cleaning ____/____/____ dental x-rays ____/____/____

Date of most recent treatment (other than cleaning) _____/_____/_____ Referred by ____________________

What type of toothbrush do you use? ☐ manual ☐ electric How often do you floss? ____________________

Previous Dentist ______________________________ For how long? ____________________

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your immediate concern? ____

____

PLEASE ANSWER THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 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? ________	☐	☐
a. If so, at what age? ________		
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? ________	☐	☐

GUM AND BONE	YES	NO
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? ________	☐	☐
8. Have you ever had or been told that you have gum loss, gum disease, or bone loss between your teeth? ________	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth or swollen and puffy gums? ________	☐	☐
10. Is there anyone with a history of periodontal disease in your family or history of loosing all their teeth? ________	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? ________	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? ________	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? ________	☐	☐

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years? ________	☐	☐
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? ________	☐	☐
16. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ________	☐	☐
17. Do you have grooves or notches on your teeth near the gum line? ________	☐	☐
18. Have you ever broken teeth, chipped teeth, or had a toothache, or cracked filling? ________	☐	☐
19. Do you frequently get food caught between any teeth? ________	☐	☐

BITE AND JAW JOINT

Question	YES	NO
20. Does your jaw joint ever have pain, sounds (popping, cracking) or experience limited opening or locking?	☐	☐
21. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐	☐
22. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
23. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
24. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
25. Are your teeth developing spaces or becoming more loose?	☐	☐
26. Do you have more than one bite or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	☐	☐
27. Do you place you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
28. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habit?	☐	☐
29. Do you clench or grind your teeth together in the daytime/nighttime or ever make them sore?	☐	☐
30. Do you have any problems with sleep (restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
31. Have you ever had a sleep study or been diagnosed with sleep apnea?	☐	☐
32. Do you wear or have ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS

Question	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth gums) that you would like to change? (color, spaces, size, shape, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self-conscious about the apperance of your teeth?	☐	☐
36. Have you been disappointed with the apperance of previous dental work?	☐	☐

Patient's Signature ______________________ Date __________

Doctor's Signature ______________________ Date __________

© 2024 Kois Center, LLC