Dental Health & Medical History Questionnaire

Please complete this comprehensive dental and medical history form to help us provide you with the best possible care. All information is confidential.

Patient Information

Please provide your basic details.

Full Name *

Date of Birth (MM/DD/YYYY) *

Phone Number *

Email Address

Home Address

Primary Dental Concerns

Let us know your main reason for visiting.

What is your primary dental concern or reason for today's visit? *

Dental History

Tell us about your dental care background.

When was your last dental visit? *

- ◯ Within the last 6 months
- ◯ 6-12 months ago
- ◯ Over a year ago
- ◯ Never

Have you ever had any negative dental experiences? *

- ◯ Yes
- ◯ No

If yes, please describe your negative dental experience(s):

Do you have dental anxiety or fear? *

- ◯ Yes
- ◯ No

If yes, please describe your dental anxiety or fear:

Current Dental Symptoms

Check any symptoms you are currently experiencing.

Which of the following dental symptoms are you experiencing? (Select all that apply)

- ☐ Tooth pain or sensitivity
- ☐ Bleeding gums
- ☐ Swollen gums
- ☐ Loose teeth
- ☐ Bad breath
- ☐ Jaw pain or clicking
- ☐ Mouth sores or ulcers
- ☐ Broken or chipped teeth
- ☐ Other

Please provide details for any checked dental symptoms above:

Oral Hygiene Habits

Share your daily oral care routine.

How often do you brush your teeth? *

- ◯ Twice a day or more
- ◯ Once a day
- ◯ A few times a week
- ◯ Rarely

How often do you floss? *

- ◯ Daily
- ◯ A few times a week
- ◯ Rarely
- ◯ Never

Which additional oral hygiene products do you use?

- ☐ Mouthwash

- [ ] Interdental brushes
- [ ] Tongue scraper
- [ ] Water flosser
- [ ] None
- [ ] Other

Please specify any other oral hygiene products you use:

Medical History Screening

Please answer the following medical history questions.

Are you currently under the care of a physician? *

- ◯ Yes
- ◯ No

If yes, please explain:

Are you currently taking any medications? *

- ◯ Yes
- ◯ No

If yes, please list your current medications:

Do you have any allergies (medications, latex, etc.)? *

- ◯ Yes
- ◯ No

If yes, please list your allergies:

Have you ever been hospitalized or had surgery? *

- ◯ Yes
- ◯ No

If yes, please provide details:

Medical Conditions Checklist

Check any conditions that apply and provide details if needed.

Please check any of the following medical conditions you have or have had:

- ☐ Heart condition
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Asthma or lung disease
- ☐ Bleeding disorder
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disorder
- ☐ Cancer
- ☐ Epilepsy or seizures
- ☐ HIV/AIDS
- ☐ Other

Please provide details for any checked medical conditions above:

Lifestyle Factors

Tell us about your lifestyle habits.

Do you smoke or use tobacco products? *

- ◯ Yes
- ◯ No

Do you consume alcohol? *

- ◯ Yes
- ◯ No

Do you use recreational drugs? *

- ◯ Yes
- ◯ No

If yes to any of the above, please provide details:

Consent & Acknowledgment

Please review and acknowledge the following statements.

I acknowledge and consent to the following: *

- ☐ I have answered all questions truthfully to the best of my knowledge.
- ☐ I understand the importance of providing accurate medical and dental information.
- ☐ I authorize the dental team to contact my physician if necessary for my care.

Signature