DENTAL HISTORY

Patient 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 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN?

PERSONAL HISTORY

PLEASE ANSWER YES OR NO TO THE FOLLOWING: 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 had braces, orthodontic treatment or had your bite adjusted, and at what age? ☐ ☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or fatal trauma? ☐ ☐

GUM AND BONE

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

7. Do your gums bleed sometimes or are they ever painful when brushing of flossing? ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? ☐ ☐
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 do you have difficulty eating an apple? ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ☐ ☐

TOOTH STRUCTURE

PLEASE ANSWER YES OR NO TO THE FOLLOWING: 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 or do you have difficulty swallowing any food? ☐ ☐
16. Do you feel or notice any holes(i.e. pitting, craters) on the biting surface of your teeth? ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ☐ ☐
20. Do you frequently get food caught between any teeth? ☐ ☐

BITE AND JAW JOINT

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ☐ ☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? ☐ ☐
26. Are your teeth developing spaces or becoming more loose? ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap you teeth together, or shift your jaw to make your teeth fit together? ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore? ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ☐ ☐
32. Do you wear or have you ever worn a bite appliance? ☐ ☐

SMILE CHARACTERISTICS

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape,color, size, display)? ☐ ☐
34. Have you ever whitened (bleached) your teeth? ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? ☐ ☐

Patient's Signature | Date | Doctor's Signature | Date

MEDICAL HISTORY

Patient Name | Nickname | Age

Name of Physician/and their specialty

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

Most recent physical examination | Purpose

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO
1. hospitalization for illness or injury	☐	☐
2. an allergic or bad reaction to any of the following:		
aspirin, ibuprofen, acetaminophen, codeine	☐	☐
penicillin	☐	☐
erythromycin	☐	☐
tetracycline	☐	☐
sulfa	☐	☐
local anesthetic	☐	☐
fluoride	☐	☐
chlorhexidine (CHX)	☐	☐
metals (nickel, gold, silver)	☐	☐
latex	☐	☐
other (fruit, nuts, milk, red dye...)		
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 (e.g . Joint replacement, breast implant)	☐	☐
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 (e.g. asthma, stuffy nose, sinus congestion)	☐	☐
16. sleep problems (e.g.sleep apnea, snoring, insomnia, restless sleep, bedwetting)	☐	☐
17. kidney disease	☐	☐
18. liver disease or jaundice	☐	☐
19. vertigo (e.g. the room is spinning)	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome)	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c=)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia)	☐	☐
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates)	☐	☐

	YES	NO
27. arthritis or gout	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma	☐	☐
30. contact lenses	☐	☐
31. head or neck injuries	☐	☐
32. epilepsy, convulsions (seizures)	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34. viral infections and cold sores	☐	☐
35. any lumps or swelling in the mouth	☐	☐
36. hives, skin rash, hay fever	☐	☐
37. STI/STD/HPV	☐	☐
38. hepatitis (type)	☐	☐
39. HIV/AIDS	☐	☐
40. tumora, abnormal growth	☐	☐
41. radiation therapy	☐	☐
42. chemotherapy, immunosuppressive medication	☐	☐
43. emotional difficulties	☐	☐
44. psychiatric treatment or antidepressant medication	☐	☐
45. concentration problems, or ADD/ADHD diagnosis	☐	☐
46. alcohol/recreational drug use	☐	☐

ARE YOU:

	YES	NO
47. presently being treated for any other illness	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea)	☐	☐
49. taking medication for weight management	☐	☐
50. taking dietary supplements	☐	☐
51. often exhausted or fatigued	☐	☐
52. experiencing frequent headaches or chronic pain	☐	☐
53. a smoker, smoked previously or other (smokeless tobacco, vaping, e-cigarettes, cannabis)	☐	☐
54. considered a touchy/sensitive person	☐	☐
55. often unhappy or depressed	☐	☐
56. taking birth control pills	☐	☐
57. currently pregnant	☐	☐
58. diagnosed with a 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, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

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

Patient's Signature | Date | Doctor's Signature | Date

Dr CLAUDE DAVID SPRCP inc.

Clinique de chirurgie buccale et maxillo-faciale

CONFIDENTIAL QUESTIONNAIRE

First name & surname:

Date of birth:

Address:

City:

Postal Code:

Telephone:

HOME | OFFICE | CELL

Email:

Referring dentist:

Family Physician:

DENTAL INSURANCE

Insurance company name:

Subcriber's name:

Subcriber's birthday:

Group/Program number:

Id number:

Date:

Signature :

Send the completed form to info@drclaudedavid.com