

## Patient History

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Initial

Referred by: \_\_\_\_\_

Previous dentist: \_\_\_\_\_ For how long: \_\_\_\_\_

Date of most recent dental exam: \_\_\_\_\_

I have routinely seen my dentist every:  3-4 Months  6 months  12 months  Not often

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

What is your immediate concern? \_\_\_\_\_

Are you fearful of dental treatment?  Yes  No How fearful? (1-10): \_\_\_\_\_

Have you ever had an unfavorable dental experience?  Yes  No

Have you ever had complications from past dental treatment?  Yes  No

Have you ever had trouble getting numb or had any reactions to local anesthesia?  Yes  No

Did you ever have braces, orthodontic treatment, or have your bite adjusted?  Yes  No

If yes, at what age? \_\_\_\_\_

Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?  Yes  No

## Gum and Bone

Please select all that apply to you:

- Bloody or painful gums when brushing or flossing
- Previous gum disease or bone loss around teeth
- Unpleasant taste or odor in mouth
- Family history of periodontal disease
- Gum recession
- Loose teeth (without any injury) or difficulty eating an apple
- Burning sensation or pain in mouth not related to teeth

## Tooth Structure

Please select all that apply to you:

- Cavities within the past 3 years
- Amount of saliva seems to be too little or difficulty swallowing food
- Holes on the biting surface of teeth
- Teeth are sensitive to hot, cold, biting, sweets, or brushing
- Teeth have grooves/notches near gumline
- Broken teeth, chipped teeth, or cracked filling causing toothache
- Food often gets caught in between teeth

### Bite and Jaw Joint

Please select all that apply to you:

- You have problems with your jaw joint (pain, sounds, limited opening, locking, popping)
- You feel like your lower jaw has to push back when you bite your back teeth together
- You avoid or have difficulty chewing gum, carrots, nuts, bread, protein bars, or other hard, dry foods
- Your teeth have changed in the past 5 years (shorter, thinner, worn) or your bite has changed
- Your teeth are becoming more crooked, crowded, or overlapped
- Your teeth are developing spaces or becoming more loose
- You have trouble finding your bite or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together
- You place your tongue in between your teeth or close your teeth against your tongue
- You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- You clench or grind your teeth together in daytime or make them sore
- You have problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache, or an awareness of your teeth
- You wear or have worn a bite appliance

### Smile Characteristics

Please select all that apply to you:

- There is something about the appearance of your teeth you would like to change (shape, colour, size)
- You have whitened (bleached) your teeth
- You have felt uncomfortable or self-conscious about your teeth appearance
- You have been disappointed about the appearance of previous dental work

### Medical History

Name of physician and their specialty: \_\_\_\_\_

Most recent physical examination and purpose: \_\_\_\_\_

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

### Do you or have you ever had:

Hospitalization for illness or injury? Reason: \_\_\_\_\_

An allergic or bad reaction to any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Aspirin, Ibuprofen, Acetaminophen, Codeine | <input type="checkbox"/> Penicillin                    |
| <input type="checkbox"/> Erythromycin                               | <input type="checkbox"/> Tetracycline                  |
| <input type="checkbox"/> Sulfa                                      | <input type="checkbox"/> Local Anesthetic              |
| <input type="checkbox"/> Fluoride                                   | <input type="checkbox"/> Metals (Nickel, Gold, Silver) |
| <input type="checkbox"/> Latex                                      | <input type="checkbox"/> Nuts                          |
| <input type="checkbox"/> Fruit                                      | <input type="checkbox"/> Other: _____                  |
-

Please select all of the following that you have or have ever had:

- |   |   |
|---|---|
| <input type="checkbox"/> Heart problems or cardiac stent within last 6 months                 | <input type="checkbox"/> Digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) |
| <input type="checkbox"/> History of infective endocarditis                                    | <input type="checkbox"/> Osteoporosis or osteopenia (i.e. taking biphosphates)                                  |
| <input type="checkbox"/> Artificial heart valve, repaired heart defect                        | <input type="checkbox"/> Arthritis  |
| <input type="checkbox"/> Pacemaker, implantable defibrillator                                 | <input type="checkbox"/> Autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)                     |
| <input type="checkbox"/> Orthopedic implant (joint replacement)                               | <input type="checkbox"/> Glaucoma   |
| <input type="checkbox"/> Rheumatic or scarlet fever   | <input type="checkbox"/> Contact lenses   |
| <input type="checkbox"/> High or low blood pressure   | <input type="checkbox"/> Head or neck injury  |
| <input type="checkbox"/> A stroke (taking blood thinners)                                     | <input type="checkbox"/> Epilepsy or convulsions (seizures)   |
| <input type="checkbox"/> Anemia or other blood disorders                                      | <input type="checkbox"/> Neurological disorders (ADD, ADHD, prion disease)                                      |
| <input type="checkbox"/> Prolonged bleeding due to a slight cut (INR > 3.5)                   | <input type="checkbox"/> Viral infections or cold sores   |
| <input type="checkbox"/> Pneumonia, emphysema, shortness of breath, sarcoidosis               | <input type="checkbox"/> Any lumps or swelling in the mouth   |
| <input type="checkbox"/> Tuberculosis, measles, or chicken pox                                | <input type="checkbox"/> Hives, skin rash, hay fever  |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> STI / STD / HPV  |
| <input type="checkbox"/> Breathing or sleeping problems (i.e. sleep apnea, snoring, or sinus) | <input type="checkbox"/> Hepatitis _____  |
| <input type="checkbox"/> Kidney disease   | <input type="checkbox"/> HIV / AIDS   |
| <input type="checkbox"/> Liver disease  | <input type="checkbox"/> Tumor or abnormal growth   |
| <input type="checkbox"/> Jaundice   | <input type="checkbox"/> Radiation therapy  |
| <input type="checkbox"/> Thyroid, parathyroid disease, or calcium deficiency                  | <input type="checkbox"/> Chemotherapy or immunosuppressive medication   |
| <input type="checkbox"/> Hormone deficiency   | <input type="checkbox"/> Emotional difficulties   |
| <input type="checkbox"/> High cholesterol or taking statin drugs                              | <input type="checkbox"/> Psychiatric treatment  |
| <input type="checkbox"/> Diabetes (HbA1c)   | <input type="checkbox"/> Antidepressant medication  |
| <input type="checkbox"/> Stomach or duodenal ulcer  | <input type="checkbox"/> Alcohol / recreational drug use  |

Please explain and date the above selected items:

## Are You:

Please select all of the following that apply to you:

- Presently being treated for any other illness
- Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)
- Taking medication for weight management
- Taking dietary supplements
- Often exhausted or fatigued
- Experiencing frequent headaches
- A smoker, previously smoked, or use smokeless tobacco
- Often unhappy or depressed
- On a form of birth control
- Currently pregnant/breast-feeding
- Diagnosed with prostate cancer



#215, 840 St. Albert Trail  
St. Albert, AB T8N 7V2  
P: 780.347.8080  
E: info@jensenlakesdental.com  
www.jensenlakesdental.com

**Dr. Beom (Michael) Park**  
Certified Specialist in Periodontics  
and Prosthodontics

**Dr. Chiungyun (Kiri) Chang**  
Certified Specialist in Periodontics

---

Please explain and date the above selected items:

---

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

---

**List all medications, supplements, and/or vitamins taken within the last two years:**

Drug and purpose: \_\_\_\_\_

Drug and purpose: \_\_\_\_\_

Drug and purpose: \_\_\_\_\_

Drug and purpose: \_\_\_\_\_

**Please advise the office in the future of any change(s) in your medical or dental history as well as medications you may be taking.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

---

---