Dr. Steven Cload
Southcentre Dental Clinic
where your smile begins

DENTAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

The following information is required to enable us to fully evaluate your dental history and provide complete options for your future care based on both your dental requirements and your satisfaction with your teeth.

1. When was your last dental hygiene appointment? _____
2. Are you experiencing any discomfort at this time? Yes No
3. Do you currently experience any of the following?

Loose Teeth	Sensitive Teeth	Swelling in Mouth
Bleeding Gums	Missing Teeth	Food packing between teeth
Unsatisfactory Dentures	Sore Gums	Floss shredding between teeth
Bad Breath	Unsatisfactory Crowns or Bridges	

4. Have you ever had any of the following?

Root Canals	Oral Cancer
Orthodontics	Grinding Appliance Therapy
Crowns/Bridges	Oral Surgery
Implants	Periodontal Therapy

5. Are you happy with the appearance of your teeth? Yes No
   If No, what would you like to change or discuss with us?

Color	Crowding	Overbite	Length
Spacing	Shape	Silver Fillings	Too Much Gum Showing

6. As part of your examination we will also analyze the condition of your bite, jaw joints, and muscles of the head and neck. Many people experience symptoms they feel are "normal" or may be caused by other things such as allergies or stress. Many of these symptoms may be in relation to your bite. We would like you to answer these questions as honestly as possible even if you do not feel they are in direct correlation to your bite.
   Do you suffer from:

Recurrent headaches	Insomnia	Tired Eyes/Red Eyes
Migraines	Grinding of Teeth	Pain Behind the Eyes
Neck Pain	Jaw Locking	Ear Ache
Shoulder Pain	Pain with Chewing	Ringing/Buzzing in Ears
Back Pain	Clenching of Teeth	Dizziness
Tingling in Hands/Arms	Jaw Joint Noise	Facial Numbness
Jaw Stiffness	Difficulty swallowing	Congested ears

7. Do you see a chiropractor, massage therapist, and/or a physiotherapist on a regular basis?
   Yes No
9. Is time a factor in getting your dental work done? Yes No
10. How healthy do you want us to get your teeth?
    Don't really care Average health The best
11. At what point would you like us to initiate treatment?
    Tooth hurts or breaks Something isn't ideal Something is worsening
12. What quality of dentistry do you want us to recommend?
    "Just patch it" Good Best
13. We have the unique ability to look at your mouth from three perspectives. Which of these would you like us to use for you? (Please check all that apply) General dentist Cosmetic dentist Functional dentist
14. **Is there anything that you would like us to know about your previous dental history that would assist us in providing you with the best-individualized treatment that we have available?**

Patient Signature: _____ Date: _____

Thank you for taking the time to answer these pertinent questions. We will now be able to provide you with a thorough exam and provide you with customized treatment options that will suit you requests, concerns and symptoms.

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Medical History Questionnaire

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so why? Yes No Not sure / maybe
2. When was your last medical checkup? _____
3. Has there been any change in your general health in the past year? If yes please explain.
   Yes No Not sure / maybe
4. Are you taking any medicine, non-prescription drugs or herbal supplements of any kind? If yes please list. Yes No Not sure / maybe
5. Have you ever been advised by your doctor to take antibiotics before dental treatment?
   Yes No Not sure / maybe
6. Do you have a bleeding problem or bleeding disorder?
   Yes No Not sure / maybe
7. Do you smoke or chew tobacco products?
   Yes No Not sure / maybe
8. **For women only:** Are you breast-feeding or pregnant? If pregnant what is the expected delivery date? Yes No Not sure / maybe

Do you have or have you ever had any of the following? Please check.

Shortness of breath	Liver disease / jaundice
Tuberculosis	Latex sensitivity
Cancer	Artificial joints
Steroid therapy	Kidney trouble
Stomach ulcers	Radiation / chemotherapy
Arthritis	Epilepsy / seizures
Thyroid	Diabetes
Drug / Alcohol dependency	Hepatitis
Aids/HIV	Sickle cell disease
Allergies	Neurological disorders
Reaction to medication or injections	Psychiatric / psychological
Heart condition / heart attack	Headaches
Congenital heart disease	Asthma
Heart murmur	Stroke
High blood pressure	Pacemaker
Mitral valve prolapsed	Artificial heart valve

Do you have or have you had any disease, condition or problem not listed? Yes No
If yes, please describe _____
To the best of my knowledge, the above information is correct:
Patient/Parent/Guardian Signature:_____Date:_____
Dentist Signature:_____ Date:_____

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