CASTLE HILLS DENTAL
WHERE YOUR SMILE WILL
LOOK AND FEEL LIKE ROYALTY

MEDICAL & DENTAL HISTORY

Thank you for helping us provide you with safe & personalized care.

1. PATIENT INFORMATION

Patient Name: _____ Phone: (____) _____

Email: _____

Address: _____

2. MEDICAL HISTORY

Do you have or have you had any of the following?

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Asthma
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Cancer
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint(s)
- ☐ Migraines
- ☐ Hearing Aids
- ☐ Osteoporosis
- ☐ Obesity
- ☐ Pre-Med
- ☐ HIV/AIDS
- ☐ Sleep Apnea
- ☐ CPAP
- ☐ Lung Disease
- ☐ GERD (Acid Reflux)
- ☐ Lupus
- ☐ Cholesterol (High)
- ☐ ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Other: _____

Current Medications: _____

_____

Medication Allergies: _____

_____

Allergies (Please list): _____

_____

Other Medical Conditions: _____

_____

Are you pregnant? ☐ YES ☐ NO

If yes, Due Date: _____

3. DENTAL HISTORY

Do you currently have or have you had any of the following?

- ☐ Tooth Pain
- ☐ Tooth Sensitivity
- ☐ Bleeding Gums
- ☐ Gum Disease
- ☐ Grinding or Clenching
- ☐ TMJ / Jaw Problems
- ☐ Dental Anxiety
- ☐ Previous Orthodontic Treatment
- ☐ Dentures or Partials
- ☐ Previous Oral Surgery
- ☐ Previous Dental Trauma
- ☐ Other: _____

Last Dental Visit: _____

Last x-rays: _____

Approximate date of last teeth cleaning: _____

How often do you brush your teeth? _____

How often do you floss? _____

Have you ever been instructed on the proper care of your mouth?	☐ YES ☐ NO
Do you like the appearance and/or color of your teeth?	☐ YES ☐ NO
Do heat, cold, sweets or pressure cause pain in your mouth?	☐ YES ☐ NO
Does food catch between your teeth?	☐ YES ☐ NO
Do your gums bleed while brushing?	☐ YES ☐ NO
Do your gums feel tender or swollen?	☐ YES ☐ NO
Have you noticed any loosening of your teeth?	☐ YES ☐ NO

Have you ever had:

Periodontal Treatment?	☐ YES ☐ NO	Injury to or surgery of the head, neck, or mouth?	☐ YES ☐ NO
Orthodontic Treatment?	☐ YES ☐ NO	Your teeth or bite adjusted?	☐ YES ☐ NO
Oral Surgery?	☐ YES ☐ NO	A night guard or other appliance?	☐ YES ☐ NO

12. Have you ever experienced any of the following problems of the jaw?

Pain (in the joint, ear, or side of face)?	☐ YES ☐ NO	Difficulty in opening or closing?	☐ YES ☐ NO
Clicking, popping, or dislocation of the jaw?	☐ YES ☐ NO	Difficulty in chewing?	☐ YES ☐ NO

13. With regard to the following habits, do you:

Clench or grind your teeth while awake or asleep?	☐ YES ☐ NO
Bite your lips or cheeks regularly?	☐ YES ☐ NO
Hold foreign objects (such as pencils, pipe, nails, etc.) with your teeth or bite your fingernails?	☐ YES ☐ NO
Mouth breathe while awake or asleep?	☐ YES ☐ NO

14. Do you generally tolerate dental treatment well? ☐ YES ☐ NO

4. ADDITIONAL INFORMATION

Please share any additional information you feel is important for us to know.

_____

_____

_____

5. PATIENT ACKNOWLEDGMENT

I certify that the information provided above is true and complete to the best of my knowledge.
I understand that providing accurate information is important for my safe and effective care.

_____ _____

Patient / Guardian Signature Date