ADULT ORAL AND SYSTEMIC HEALTH HISTORY

While dentistry is our primary purpose, we believe you want a healthy mouth and a healthy body. Let us partner with you for both.

Name______________________________ Date of Birth______________ Today's Date______________

Signature______________________________ What is your most important concern today?

Caries (tooth decay):

Do (Are) you:

- Cavity prone? .... Y N
- Consume sugary sugary foods/beverages? .... Y N
- Consume citrus flavored beverages? .... Y N
- Experience dry mouth? .... Y N
- Have heartburn? .... Y N
- Have acid reflux? .... Y N

Periodontal Disease:

Do you have:

- Gingivitis? .... Y N
- Gum disease? .... Y N
- Bleeding gums when brushing/flossing? .... Y N
- Recession/exposed roots? .... Y N
- Loose/drifting teeth? .... Y N
- Open contacts/get food stuck? .... Y N

Oral Cancer:

Do you:

- Smoke? .... Y N
- Chew tobacco? .... Y N
- Have persistent sore spots? .... Y N
- Have lumps/bumps in head/neck? .... Y N
- Feel a constant lump in throat? .... Y N
- Want a saliva test for HPV risk? .... Y N

Function/Bite/TMJ Dysfunction:

Do you:

- Have missing teeth (other than wisdom)? .... Y N
- Have chewing discomfort? .... Y N
- Hear sounds in your jaw joints? .... Y N
- Have frequent headaches? .... Y N
- Have frequent jaw/facial pain? .... Y N
- Previous treatment for TMJ? .... Y N
  - If yes, when? ______________
- Wear removable dentures/partial dentures? .... Y N
  - If so, are they comfortable and well-fitting? .... Y N

Medical Care:

Do (Are) you:

- Being treated for a medical condition? .... Y N
- Feel well cared for/trust your medical team? .... Y N
- Seek annual prevention? .... Y N

Cardiovascular Health:

Do (Have) You:

- Been diagnosed with cardiovascular disease? .... Y N
- Been diagnosed with high blood pressure? .... Y N
  - ☐ Controlled ☐ Medicated
- Had a heart attack? .... Y N
  - If yes, when? ______________
- Had a stroke? .... Y N
  - If yes, when? ______________
- Had bypass surgery or stints? .... Y N
  - If yes, when? ______________
- Have AFib or History of? .... Y N
  - If yes, when? ______________
- Have shortness of breath? .... Y N
- Have chest pains? .... Y N
- Family history of cardiovascular disease? .... Y N
- Take anti-cholesterol medications? .... Y N
- Monitor blood pressure at home? .... Y N

Cancer:

Do you:

- Have cancer diagnosis/history? .... Y N
  - Type: ______________
  - Current Treatment: ______________
- Suspect/fear cancer in your body currently? .... Y N
- Have risk factors for specific cancer? .... Y N

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PreDiabetes and Diabetes:

Do (Are) you:

Have a diabetes/prediabetes diagnosis?.................. Y N

☐ Type I ☐ Type II ☐ Gestational

Take medications for Diabetes? .... Y N

Take medications for Hypertension? .... Y N

More than 10% above ideal body weight?................ Y N

Have waist circumference over 35”(women) or 40” (men)?.. Y N

Have biologic family with diabetes?.......................... Y N

Have bleeding gums when brushing/flossing? .... Y N

Brain Health:

Have (Do) you?

Been diagnosed with Depression?........................... Y N

Feel sad, anxious, energy depleted?........................ Y N

Lost interest in activities that brought you happiness? .... Y N

Been diagnosed with Dementia?.............................. Y N

Experience “brain fog”? .... Y N

Forget names or words?.. Y N

Frequently forget location of keys/phone/places/ directions? .... Y N

Other Organ Dysfunction:

Any treatment for diseases of:

Thyroid?...Y N

Lungs?.. Y N

Liver?.. Y N

Kidneys?... Y N

Uterus? .... Y N

Pancreas? .... Y N

Brain? .... Y N

Women:

Are you:

Pregnant?..Y N

Currently nursing? .... Y N

Bone Health:

Do you:

Have osteopenia?...Y N

Have osteoporosis?..Y N

Have abnormal bone density test?............................Y N

Have history of medications for osteoporosis?...........Y N

Suspect a Vitamin D deficiency?...............................Y N

Dependency/Addiction:

Do (Are) you:

In recovery currently? .... Y N

Being treated for addiction?...................................... Y N

Consume nicotine/tobacco? .... Y N

If so, what form? ____________

Consume cannabis?... Y N

If so, what form? ____________

Chew tobacco?.. Y N

Depend on prescription or non-prescription drugs to:

☐ Sleep ☐ Wake ☐ Relieve Pain

Consume more than three 8 oz servings of caffeine a day? .... Y N

Feel addicted to sugar? .... Y N

Joints:

Do you have:

Joint inflammation?...Y N

Chronic pain? ....Y N

Arthritis? ....Y N

History of joint surgery?..Y N

Type: ____________

Date: ____________

History of joint replacement?.....................................Y N

Type: ____________

Date: ____________

Food and Drink:

Do you:

Follow a special diet? ....Y N

Aspire to change your diet?..Y N

Experience weight gain? ....Y N

Desire a weight change?..Y N

Consume sugary foods/drinks regularly? ....Y N

List regularly consumed sugary foods/drinks:

List any other beverages you consume on a regular basis:

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Pharmacology:

List all medications you're currently taking, including prescription and OTC meds, vitamins and supplements:

Are you interested in reducing amount of meds currently taking? .... Y N

Sleep:

Do you (or your bed partner) ever:

- Snore? .... Y N
- Experience interruptions in breathing during sleep? .... Y N
- Have difficulty sleeping/staying asleep? .... Y N
- Feel tired or daytime fatigue? .... Y N
- Have mornings that feel awful? .... Y N
- Family history of sleep apnea? .... Y N

Exercise:

Do you:

Exercise daily? .... Y N

How often:

What type(s):

Have exercise goals you hope to achieve? .... Y N

Allergies, Food Sensitivities, and Chronic Inflammatory Conditions:

Do you have:

- Irritable Bowel syndrome .... Y N
- Fibromyalgia? .... Y N
- Arthritis? .... Y N
- Chronic fatigue syndrome? .... Y N
- Insulin resistance? .... Y N
- Periodontal/gum disease? .... Y N
- Allergies? .... Y N

If yes, list all:

- Food Sensitivities? .... Y N

If yes, list all:

- Heart burn/acid reflux? .... Y N
- Regurgitation? .... Y N
- Weight gain? .... Y N
- GI bloating? .... Y N
- Constipation? .... Y N
- Diarrhea? .... Y N
- Red, patchy, itchy skin or itchy ears? .... Y N
- Foods that make you feel sluggish, sick or guilty? .... Y N

Do you have any other questions or concerns that you would like to share with us today?

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