Port Warwick
DENTAL ARTS
COMPREHENSIVE DENTISTRY FOR TOTAL WELLNESS, FUNCTION AND BEAUTY

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_____ What would you like us to call you?_____

Date of Birth_____ Age_____ List medical conditions for which you are currently being treated_____

_____

Signature_____ Today's Date_____

Caries (tooth decay):

Do you consider yourself cavity prone?	Y	N
Do you consume sugary foods regularly?	Y	N
Do you consume any fruit juices, sodas or sports drinks regularly?	Y	N
Does your mouth feel dry?	Y	N
Do you have heartburn or reflux?	Y	N

Periodontal (Gum) Disease:

Have you been told you have gingivitis or other forms of gum disease in the past?	Y	N
Do your gums ever bleed when you brush or floss?	Y	N
Do you have gum recession or exposed root surfaces?	Y	N
Do you have any loose teeth, drifting teeth, or areas that collect food when you eat?	Y	N
Do you have a bad taste in your mouth or odor to your breath?	Y	N

Oral Cancer:

Do you smoke or vape (electronic, standard cigarettes or marijuana) or chew tobacco?	Y	N
Do you have any persistent sore spots in your mouth or lumps/bumps in you head or neck?	Y	N
Do you feel as if you have a lump in your throat?	Y	N
Recognizing that HPV infection is the single biggest risk factor for oral/pharyngeal cancer, do you want a saliva test to see if you are at risk?	Y	N

Function/Bite/TMJ Dysfunction:

Do you have any missing teeth other than wisdom teeth?	Y	N
Do you ever experience discomfort when chewing?	Y	N
Do your jaw joints click, pop or make grinding sounds?	Y	N
Do you experience frequent headaches or jaw/facial pain?	Y	N
Do your joints ever get stuck or locked?	Y	N
Have you ever been treated for a jaw joint problem? If so, by what methods:	Y	N
Do you wear any removable dentures or partial dentures?	Y	N
If so, are they comfortable and well-fitting?	Y	N
Do you like the way they look?	Y	N

Medical Care:

Do you wish you felt better cared for or more trusting of your medical team?	Y	N
Do you seek annual preventative services?	Y	N

Cardiovascular Health:

Are you currently being treated for heart disease?	Y	N
Have you had any heart valves replaced?	Y	N
Do you have a history of heart attack, stroke, bypass surgery or stints?	Y	N
Do you experience shortness of breath or chest pain?	Y	N
Do you have a family history of heart disease?	Y	N
Do you take anti-cholesterol medicine?	Y	N
Have you ever been diagnosed or treated for high blood pressure?	Y	N
If so, is it currently controlled?	Y	N
Do you currently take blood pressure medicine?	Y	N
Do you monitor your own blood pressure?	Y	N

Cancer

Do you have a cancer diagnosis or history?	Y	N
Are you currently undergoing cancer treatment?	Y	N
Do you currently have a suspicion or fear of cancer in your body?	Y	N
Do you have a family history or any known risk factors for a specific cancer?	Y	N

PreDiabetes and Diabetes

Have you ever been diagnosed with prediabetes or diabetes?	Y	N
Do you take medications for diabetes?	Y	N
Are you more than 10% above your ideal body weight or have a waist circumference over 35" for women, or 40" for men?	Y	N
Do you have any biological family members with diabetes?	Y	N
Do your gums bleed when you brush or floss?	Y	N
Do you monitor your blood sugar at home?	Y	N

Tick Borne Illness

Have you ever been diagnosed with Lyme disease, Alpha gal or other tick borne illnesses?	Y	N

Brain health

Have you been diagnosed with dementia, Alzheimer's depression, anxiety disorder or any other brain function ailment? *(circle all that apply)*	Y	N
Do you frequently feel sad, energy depleted or anxious?	Y	N
Have you lost interest in activities that used to make you happy?	Y	N
Do you experience brain fog?	Y	N
Do you have difficulty remembering names or words you want to use?	Y	N
Do you frequently forget where you put your keys or phone or how to get from place to place?	Y	N

Other Organ Dysfunction

Are you aware of or being tested for any vital organ diseases such as diseases of the thyroid, lungs, liver, kidneys, uterus, pancreas or brain?	Y	N

Dependency / Addiction

Are you currently in recovery or being treated for addiction?	Y	N
Do you smoke or chew tobacco?	Y	N
If yes, do you want to quit?	Y	N
Do you depend on prescription or non prescription drugs to sleep, wake or relieve pain?	Y	N
Do you consume caffeine in excess of three 8 oz servings a day?	Y	N
Do you feel you are addicted to any sugar?	Y	N

Bone health

Have you been diagnosed with osteopenia or osteoporosis?	Y	N
Have you had an abnormal bone density test?	Y	N
Have you been treated with oral or injectable medications for osteoporosis?	Y	N
Do you take bone building supplements?	Y	N

Joints

Do you have joint inflammation, pain or arthritis?	Y	N
Have you had a history of joint surgery or joint replacement?	Y	N
Have you taken antibiotics for dental appointments as a result of joint replacement?	Y	N

Pharmacology

List all medications you're currently taking, including prescription and OTC meds, vitamins and supplements. *If necessary, please include a separate list.*

Do you have a desire to reduce the amount of prescription medication you currently take?	Y	N

Food and drink

Do you follow a special diet?	Y	N
Do you have a history of an eating disorder?	Y	N
Do you aspire to make changes to your diet?	Y	N
Do you desire a change in weight?	Y	N

List any beverages you consume on a regular basis.

Sleep

Have you ever been told that you snore?	Y	N
Does your bed partner snore?	Y	N
Do you experience gasping or interruptions in breathing during sleep?	Y	N
Do you have difficulty sleeping or falling asleep?	Y	N
Do you feel tired or fatigued during the day?	Y	N
Have you ever had a sleep study?	Y	N
Do you have a CPAP or Oral Sleep Appliance?	Y	N

Allergies, food sensitivities, and other chronic inflammatory conditions

Are you aware of any chronic inflammatory conditions such as irritable bowel syndrome, fibromyalgia, gout, arthritis, chronic fatigue syndrome, insulin resistance, or periodontal (gum) disease?	Y	N

If so, please list

Are you aware of any allergies?	Y	N

If so, please list

Have you identified any food sensitivities such as dairy, gluten or soy?	Y	N
Do you suffer from GI disturbances such as discomfort, bloating, constipation or diarrhea?	Y	N
Do you have heartburn or vomit regularly?	Y	N
Do you have difficulty losing weight despite considerable effort?	Y	N
Do you regularly eat foods that make you feel sluggish, sick or guilty?	Y	N
Do you have red, patchy or itchy skin or ears?	Y	N

Exercise

Do you exercise regularly?	Y	N

If so, how many times per week?

If so, what do you currently do for exercise?

Do you have exercise goals you hope to achieve?	Y	N

Doctor Signature _____Date_____