Elisabeth M. Gerics
DDS PA

Name: ______________________

Date: ______________________

DENTAL INFORMATION

What is the reason for your visit today? ____________

When was your last dental visit? ____________

When was your last dental cleaning? ____________

How often do you brush your teeth? ____________

How often do you floss? ____________

What texture toothbrush do you use? Soft ❑ Medium ❑ Hard ❑

Do you have sensitivity to: hot ❑ cold ❑ biting ❑ pressure ❑ sweets ❑ sour ❑ other ❑

Yes	No	Don't Know	
❑	❑	❑	Have you ever heard any clicking or popping in your jaw joints - immediately in front of your ears?
❑	❑	❑	Have you ever experienced headaches, near your temples, upon awakening in the morning?
❑	❑	❑	Have you ever experienced chewing muscle soreness or tension upon awakening in the morning?
❑	❑	❑	Have you ever had jaw joint pain during chewing?
❑	❑	❑	Has yawning or opening wide ever caused you pain?
❑	❑	❑	Has your jaw ever been stuck or locked open, even if only for a brief moment?
❑	❑	❑	Have you ever felt that your teeth didn't meet in a comfortable position?
❑	❑	❑	Has a dentist ever devoted one or more appointments to precision bite adjustment or "eqiulibration"?
❑	❑	❑	Have you ever been struck on, or received injury to the head, neck or jaw?
❑	❑	❑	Have you ever had any episodes of pain in the jaw joint?
❑	❑	❑	Have you ever ground your teeth while sleeping?
❑	❑	❑	Do you find yourself clenching your teeth during the day?
❑	❑	❑	Do your jaw muscles tire while eating or talking?
❑	❑	❑	Do you have arthritis?
❑	❑	❑	Have you ever been treated in the past for TMJ problems?
❑	❑	❑	Have you ever noticed difficulty or limitation in opening?
❑	❑	❑	Have you ever noticed recent shifting, crowding, rotating or new spaces opening?
❑	❑	❑	Have you ever noticed loose teeth?

Do You Or Have You Ever Had:

Yes	No	Don't Know	
❑	❑	❑	Orthodontics (braces)
❑	❑	❑	Periodontal (gum) treatment
❑	❑	❑	Complications from dental treatment
❑	❑	❑	Loosening of teeth
❑	❑	❑	Blisters or sores on lips or in mouth
❑	❑	❑	Food collecting between your teeth
❑	❑	❑	Oral surgery

Yes	No	Don't Know	
❑	❑	❑	Worn a nightguard or other appliance
❑	❑	❑	Bleeding or sore gums
❑	❑	❑	Swelling or lumps in mouth
❑	❑	❑	Trauma to your jaw, head, or neck
❑	❑	❑	Unpleasant taste
❑	❑	❑	Problems with bad breath (halitosis)

Esthetics:

Yes	No	Don't Know	
❑	❑	❑	Are you pleased with the appearance of your teeth?
❑	❑	❑	Do you like the shape of your teeth?
❑	❑	❑	Do you like the color of your teeth?
❑	❑	❑	Are you interested in learning how to enhance your smile?
❑	❑	❑	Is there anything you would like to change about the appearance of your teeth? ____________

Is there anything else in your past dental history you feel I should know? ______________________

____

____

MEDICAL INFORMATION

	Yes	No	Don't Know
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
Are you now under the care of a physician?	❑	❑	❑

If yes, what is/are the condition(s) being treated? ____________________

____

Date of last physical examination: ____________________

Physician: ____________________
NAME PHONE

	Yes	No	Don't Know
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	❑	❑	❑

If yes, what was the illness or problem? ____________________

____

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	❑	❑	❑

If yes, when was this operation done? ____________________

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint? ____________________

	Yes	No	Don't Know
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑	❑
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	❑	❑	❑

If yes, what medicine(s) are you taking? ____________________

Prescribed: ____________________

Over the counter: ____________________

Vitamins, natural or herbal preparations and/or diet supplements: ____________________

____

Are you allergic to or have you had a reaction to?	Yes	No	Don't Know
Local anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other antibiotics	❑	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑	❑
Sulfa drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑
Latex	❑	❑	❑
Iodine	❑	❑	❑
Hay fever/seasonal	❑	❑	❑
Animals	❑	❑	❑
Food (specify) ____________________	❑	❑	❑
Other (specify) ____________________	❑	❑	❑
Metals (specify) ____________________	❑	❑	❑

To yes responses, specify type of reaction. ____________________

____

	Yes	No	Don't Know
Do you drink alcoholic beverages?	❑	❑	❑

If yes, how much alcohol did you drink in the last 24 hours? ____________________

In the past week? ____________________

	Yes	No	Don't Know
Do you use tobacco (smoking, snuff, chew)?	❑	❑	❑

If yes, how interested are you in stopping?

(circle one) Very / Somewhat / Not interested

	Yes	No	Don't Know
Do you use drugs or other substances for recreational purposes?	❑	❑	❑

If yes, please list: ____________________

Frequency of use (daily, weekly, etc.): ____________________

Number of years of recreational drug use: ____________________

WOMEN ONLY

	Yes	No	Don't Know
Are you or could you be pregnant?	❑	❑	❑
Nursing?	❑	❑	❑
Taking birth control pills or hormonal replacement?	❑	❑	❑

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
Abnormal bleeding	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Anemia	❑	❑	❑
Arthritis	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Asthma	❑	❑	❑
Blood transfusion. If yes, date: ____________________	❑	❑	❑
Cancer/Chemotherapy/Radiation Treatment	❑	❑	❑
Cardiovascular disease. If yes, specify below:	❑	❑	❑

____ Angina
____ Arteriosclerosis
____ Artificial heart valves
____ Congenital heart defects
____ Congestive heart failure
____ Coronary artery disease
____ Damaged heart valves
____ Heart attack
____ Heart murmur
____ High blood pressure
____ Low blood pressure
____ Mitral valve prolapse
____ Pacemaker
____ Rheumatic heart disease/Rheumatic fever

	Yes	No	Don't Know
Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Disease, drug, or radiation-induced immunosurpression	❑	❑	❑
Diabetes. If yes, specify below:	❑	❑	❑

____ Type I (Insulin dependent) ____ Type II

	Yes	No	Don't Know
Dry Mouth	❑	❑	❑
Eating disorder. If yes, specify: ____________________	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux/persistent heartburn	❑	❑	❑
Glaucoma	❑	❑	❑

	Yes	No	Don't Know
Hemophilia	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Recurrent Infections	❑	❑	❑
If yes, indicate type of infection: ____________________			
Kidney problems	❑	❑	❑
Mental health disorders. If yes, specify: ____________________	❑	❑	❑
Malnutrition	❑	❑	❑
Night sweats	❑	❑	❑
Neurological disorders. If yes, specify: ____________________	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck	❑	❑	❑
Respiratory problems. If yes, specify below:	❑	❑	❑

____ Emphysema ____ Bronchitis, etc.

	Yes	No	Don't Know
Severe headaches/migraines	❑	❑	❑
Severe or rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Sinus trouble	❑	❑	❑
Sleep disorder	❑	❑	❑
Sores or ulcers in the mouth	❑	❑	❑
Stroke	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Tuberculosis	❑	❑	❑
Thyroid problems	❑	❑	❑
Ulcers	❑	❑	❑
Excessive urination	❑	❑	❑
Do you have any disease, condition, or problem not listed above that you think I should know about?	❑	❑	❑

Please explain: ____________________

____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

____________________ ____________________
SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE