GREGSON & ASSOCIATES DENTISTRY

DENTAL HISTORY

JEFFREY GREGSON, DDS

INFORMATION

Name (Full) _____ Birthdate _____

FIRST NAME / MIDDLE INITIAL / LAST NAME — MM / DD / YYYY

PREVIOUS PHYSICIAN AND/OR SPECIALTY PHYSICIAN

PREVIOUS DENTIST _____ TREATMENT (OTHER THAN A CLEANING) ____/____/____

DATE OF MOST RECENT DENTAL EXAM ____/____/____ X-RAYS ____/____/____

I ROUTINELY SEE MY DENTIST EVERY ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not Routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PERSONAL HISTORY

	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) 1 2 3 4 5 6 7 8 9 10		
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, if yes, at what age? _____	☐	☐
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma	☐	☐

GUM AND BONE

	YES	NO
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury) or feel them move when chewing?	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth?	☐	☐

TOOTH STRUCTURE

	YES	NO
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT

	YES	NO
21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?	☐	☐
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore?	☐	☐
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS

	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

OTHER _____

Patient's Signature _____ Date _____

P: (504) 849-0190 F: (504) 849-0192 A: 3812 RIDGELAKE DR STE 300, METAIRIE, LA 70002 GREGSONDENTISTRY.COM

GREGSON & ASSOCIATES DENTISTRY

MEDICAL HISTORY

JEFFREY GREGSON, DDS

INFORMATION

Name (Full) _____ Birthdate _____

FIRST NAME / MIDDLE INITIAL / LAST NAME — MM / DD / YYYY

PREVIOUS PHYSICIAN AND/OR SPECIALTY PHYSICIAN

NAME OF PHYSICIAN/AND THEIR SPECIALTY _____

MOST RECENT PHYSICAL EXAMINATION? _____ PURPOSE? _____

WHAT IS YOUR ESTIMATE OF YOUR GENERAL HEALTH? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

PERSONAL HISTORY / DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO
1. Hospitalization for Illness or Injury	☐	☐
2. An Allergic or Bad Reaction to Any of the Following:		
☐ aspirin, ibuprofen, acetaminophen, codeine.		
☐ penicillin.		
☐ sulfa.		
☐ local anesthetic.		
☐ fluoride.		
☐ chlorhexidine (Chx).		
☐ metals (nickel, gold, silver, _____.		
☐ latex.		
☐ red dye.		
☐ other _____.		
3. Heart Problems or Cardiac Stent within the Last Six Months	☐	☐
4. History or Infective Endocarditis	☐	☐
5. Artificial Heart Valve, Repaired Heart Defect (PFO)	☐	☐
6. Pacemaker or Implantable Defibrillator	☐	☐
7. Orthopedic or Soft Tissue Implant (e.g. Joint Replacement, Breast Implant)	☐	☐
8. Heart Murmur	☐	☐
9. High Blood Pressure	☐	☐
10. A Stroke (Taking Blood Thinners)	☐	☐
11. Anemia or Other Blood Disorder	☐	☐
12. Prolonged Bleeding Due to a Slight Cut (or Inr > 3.5)	☐	☐
13. Pneumonia, Emphysema, Shortness Of Breath, Sarcoidosis	☐	☐
14. Chronic Ear Infections, Tuberculosis	☐	☐
15. Breathing Problems (e.g. Asthma, Nasal Breathing, Stuffy Nose, Sinus Congestion)	☐	☐
16. Sleep Problems (e.g. Sleep Apnea, Snoring, Insomnia, Restless Sleep, Bedwetting)	☐	☐
17. Kidney Disease	☐	☐
18. Liver Disease or Jaundice	☐	☐
19. Vertigo (e.g. "The Room Is Spinning")	☐	☐
20. Thyroid, Parathyroid Disease, or Calcium Deficiency	☐	☐
21. High Cholesterol or Taking Statin Drugs	☐	☐
22. Diabetes (Hba1c=	☐	☐
23. Stomach or Duodenal Ulcer	☐	☐

	YES	NO
24. Digestive or Eating Disorders (e.g. Gastric Reflux, Bulimia, Anorexia, Celiac Disease, Crohn's Disease, or any Inflammatory Bowel Disease)	☐	☐
25. Osteoporosis/Osteopenia or ever taken an Anti-Resorptive Medications (e.g. Bisphosphonates)	☐	☐
26. Arthritis or Gout	☐	☐
27. Autoimmune disease (e.g. Rheumatoid Arthritis, Lupus, Scleroderma)	☐	☐
28. Head or Neck Injuries	☐	☐
29. Epilepsy, Convulsions (Seizures)	☐	☐
30. Neurologic Disorders (e.g. Alzheimer's Disease, Dementia, Prion Disease)	☐	☐
31. Viral Infections (e.g. Cold Sores) bacterial Infection (e.g. Lyme disease)	☐	☐
32. Any Lumps or Swelling in the Mouth	☐	☐
33. Hives, Skin Rash, Hay Fever	☐	☐
34. STD/HPV	☐	☐
35. Hepatitis (type _____)	☐	☐
36. HIV/AIDS	☐	☐
37. Tumor, Abnormal Growth	☐	☐
38. Radiation Therapy	☐	☐
39. Chemotherapy, Immunosuppressive Medication	☐	☐
40. Difficulties with Stress Management	☐	☐
41. Psychiatric Treatment, Antidepressants, Mood Stabilizing Medications	☐	☐
42. Concentration Problems or ADD/ADHD	☐	☐
43. Recreational drug use	☐	☐
ARE YOU:		
44. Presently Being Treated for any other illness	☐	☐
45. Taking Medication For Weight Management	☐	☐
46. Taking Dietary Supplements, Vitamins, and/or Probiotics	☐	☐
47. Often Exhausted or Fatigued	☐	☐
48. Experiencing Frequent Headaches or Chronic Pain	☐	☐
49. A Smoker, Smoked Previously or Other (e.g. Smokeless Tobacco, Vaping, E-Cigarettes, And Cannabis)	☐	☐
50. Considered A Touchy/Sensitive Person	☐	☐
51. Often Unhappy or Depressed	☐	☐
52. Currently Pregnant	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug _____ Purpose _____ Drug _____ Purpose _____

Drug _____ Purpose _____ Drug _____ Purpose _____

Please advise us in the future of any change in your medical history or any medications you may be taking.

Patient's Signature _____ Date _____

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