DENTAL HEALTH HISTORY

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**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Chief Dental Complaints (indicate all previous** [ **P** ] **and current** [ **C** ] **conditions)** |  **P** |  **C** |
| 1)  |  |  |
| 2) |  |  |
| 3) |  |  |
| 4) |  |  |
| **Treatment Concerns** |  **YES** |  **NO** | **Oral Hygiene** |  **YES** | **NO** |
| Any bad dental experiences? |  |  | Do you floss daily? If not how often?  |  |  |
| Any need for anxiety control? |  |  | Do you use an electric device? Toothbrush / Other |  |  |
| Are you interested in cosmetic dentistry? |  |  | Do you use mouth rinses? |  |  |
| Any physical constraints – gag reflex / swallowing? |  |  | Do you keep regular hygienic appointments? |  |  |
|  |  |
| Metals | **YES** | **NO** | Plastics |  **YES** |  **NO** |
| **Amalgams (silver/mercury fillings)** |  |  | **Acrylics (dentures / partials)** |  |  |
| Never had any |  |  | Any composite / plastic fillings? |  |  |
| Currently have *Do you want them removed?* 🞏 YES 🞏 NO |  |  | Sealants (when young)? |  |  |
| Drink water from plastic bottles? |  |  |
| Metal fillings previously removed *Removed by a holistic dentist?* 🞏 YES 🞏 NO |  |  | Chronic Infections |  **YES** |  **NO** |
| Current / previous root canals? |  |  |
| Bluish/black tattoos / spots on the gum |  |  | Any symptoms or problems? If yes, describe > |  |  |
| **Braces (orthodontics)**Had metal braces from \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_Had plastic aligners (no. of years) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you currently wear metal permanent retainers? |  |  | Wisdom or other tooth extraction?Any problems with the process? If yes, describe >\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |
|  |  |
| **Crowns**Currently/previously have/ had metal-lined crowns? |  |  | Any suspected problems with the sites? If yes, describe > |  |  |
| Were they replaced with ceramic (metal-free)? |  |  | Any suspected dead or infected teeth? If so, where? > |  |  |
| Had pediatric silver (stainless steel) crowns? |  |  | Periodontal Disease or infection? |  |  |
| Had scaling/root planning or gum surgery? |  |  |
|  |
| Dental Stress | **YES** |  **NO** | Excess Fluoride |  **YES** | **NO** |
| **Tooth grinding or clenching** Do you suspect grinding or clenching? |  |  | Have fluorosis (white spots on teeth)? |  |  |
| If your tap water fluoridated? Do you drink it? 🞏 YES 🞏 NO |  |  |
| Do you have / wear a mouth guard? |  |  |  |
| Do you have sensitive teeth? 🞏 Hot 🞏 Cold 🞏 Pressure/Chewing |  |  | Use a toothpaste with fluoride? |  |  |
| Sore jaw muscles |  |  | Currently/previously received fluoride treatments? |  |  |
| TM joint (jaw joint) symptoms |  |  | Use *Ciprofloxin* antibiotics? |  |  |
| Neck / shoulder pain |  |  | Took fluoride vitamins when young? |  |  |