DENTAL HEALTH HISTORY

REVISED MARCH 24, 2021

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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? | |  |  |