Belle Forest Dental
John R. Munro, DDS

Health History

131 Belle Forest Circle, Suite 110, Nashville, TN 37221 | 615.662.0255

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes ____________________

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No If yes ____________________

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes ____________________

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes ____________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes ____________________

Do you use tobacco? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you have any other allergies? ☐ Yes ☐ No If yes ____________________

Do you have, or have you had any of the following?

☐ AIDS/HIV	☐ Chest Pains/Angina	☐ Liver Disease	☐ Excessive Thirst
☐ Diabetes	☐ Tuberculosis	☐ Low Blood Pressure	☐ Fainting Spells/Dizziness
☐ Drug Addiction	☐ Congenital Heart Disorder	☐ Lung Disease	☐ Blood Disease
☐ Genital Herpes	☐ Heart Trouble/Disease	☐ Hay Fever	☐ Breathing Problems
☐ High Blood Pressure	☐ Hemophilia	☐ Heart Attack/Failure	☐ Stroke
☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Cold Sores/Fever Blisters	☐ Cancer
☐ Artificial Heart Valve	☐ Hepatitis B or C	☐ Heart Pacemaker	☐ Thyroid Disease
☐ Shingles	☐ Rheumatic Fever	☐ Psychiatric Care	☐ Mitral Valve Prolapse
☐ Hypoglycemia	☐ Rheumatism	☐ Radiation Treatments	☐ Osteoporosis
☐ Irregular Heartbeat	☐ High Cholesterol	☐ Anaphylaxis	☐ Heart Murmur
☐ Kidney Problems	☐ Excessive Bleeding	☐ Anemia	☐ Ulcers
☐ Frequent Headaches	☐ Artificial Joint	☐ Emphysema	☐ Yellow Jaundice
☐ Bruise Easily	☐ Asthma	☐ Arthritis/Gout	
☐ Glaucoma	☐ Sinus Trouble	☐ Scarlet Fever	
☐ Chemotherapy	☐ Blood Transfusion	☐ Hives or Rash	

Dental History
Please check any of the following problems that apply to you

☐ Sensitivity (hot, cold, sweet)	☐ Loose, tipped or shifted teeth	☐ Teeth or fillings breaking	☐ Bad Breath
☐ Grinding or clenching teeth	☐ Dry Mouth	☐ Bleeding, or swollen irritated gums	

Do you have or have you had any of the following?

☐ Dentures ☐ Braces ☐ Partial dentures ☐ Periodontal (gum) treatments

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If I could change my smile/teeth, I would...

☐ Make them whiter	☐ Repair chipped teeth	☐ Make them straighter	☐ Replace missing teeth
☐ Close spaces	☐ Replace old crowns that don't match	☐ Replace black metal fillings with tooth	☐ Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

Where would you rate your current dental health? ___________ Where would you like your dental health to be? ___________

Sleep Condition

Do you have any of the following symptoms?

- ☐ Frequent, heavy snoring
- ☐ Significant daytime drowsiness
- ☐ Gasping when waking up
- ☐ Feeling unrefreshed in the morning
- ☐ Morning headaches
- ☐ Nocturnal teeth grinding
- ☐ Jaw clicking
- ☐ Snoring affects the sleep of others
- ☐ I have been told I stop breathing while sleeping
- ☐ Nighttime choking spells
- ☐ Morning hoarseness
- ☐ Swelling in ankles or feet
- ☐ Jaw Pain

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
Use the following scale to choose the most appropriate number for each situation:

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing

	(Circle one)
Sitting and reading	0 1 2
Watching TV	0 1 2
Sitting inactive in a public place (e.g. a theater or a meeting)	0 1 2
As a passenger in a car for an hour without a break	0 1 2
Lying down to rest in the afternoon when circumstances permit	0 1 2
Sitting and talking to someone	0 1 2
Sitting quietly after lunch without alcohol	0 1 2
In a car, while stopped for a few minutes in traffic	0 1 2

If your total is...
1 to 6 = Congratulations, you are getting enough sleep.
7 to 8 = Your score is average.
9 and up = Seek the advice of a sleep specialist without delay.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, Parent or Guardian ______________________________ Date ________________

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Patient Survey

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What is the most important thing to you about your smile and dental health?

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____

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What is the most important thing to you about your visit today?

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Bite and Jaw Joint

Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)?	☐ Yes	☐ No
Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐ Yes	☐ No
Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐ Yes	☐ No
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐ Yes	☐ No
Are your teeth developing spaces or becoming more loose?	☐ Yes	☐ No
Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	☐ Yes	☐ No
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐ Yes	☐ No
Do you clench your teeth in the daytime or make them sore?	☐ Yes	☐ No
Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?	☐ Yes	☐ No
Do you wear or have you ever worn a bite appliance?	☐ Yes	☐ No

Email Address: ______________________________

Phone Number ______________________________

Please let us know your preferred method of communication ______________