



# ADULT ORAL AND SYSTEMIC HEALTH HISTORY

While dentistry is our primary purpose, we believe you want a healthy mouth and a healthy body. Let us partner with you for both.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Signature \_\_\_\_\_ What is your most important concern today? \_\_\_\_\_

## Caries (tooth decay):

**Do (Are) you:**

- Cavity prone? ..... Y N
- Consume sugary foods/beverages? ..... Y N
- Consume citrus flavored beverages? ..... Y N
- Experience dry mouth? ..... Y N
- Have heartburn? ..... Y N
- Have acid reflux? ..... Y N

## Medical Care:

**Do (Are) you:**

- Being treated for a medical condition? ..... Y N
- Feel well cared for/trust your medical team? ..... Y N
- Seek annual prevention? ..... Y N

## Periodontal Disease:

**Do you have:**

- Gingivitis? ..... Y N
- Gum disease? ..... Y N
- Bleeding gums when brushing/flossing? ..... Y N
- Recession/exposed roots? ..... Y N
- Loose/drifting teeth? ..... Y N
- Open contacts/get food stuck? ..... Y N

## Cardiovascular Health:

**Do (Have) You:**

- Been diagnosed with cardiovascular disease? ..... Y N
- Been diagnosed with high blood pressure? ..... Y N
  - Controlled  Medicated
- Had a heart attack? ..... Y N
  - If yes, when?
- Had a stroke? ..... Y N
  - If yes, when?
- Had bypass surgery or stints? ..... Y N
  - If yes, when?
- Have AFib or History of? ..... Y N
  - If yes, when?
- Have shortness of breath? ..... Y N
- Have chest pains? ..... Y N
- Family history of cardiovascular disease? ..... Y N
- Take anti-cholesterol medications? ..... Y N
- Monitor blood pressure at home? ..... Y N

## Oral Cancer:

**Do you:**

- Smoke? ..... Y N
- Chew tobacco? ..... Y N
- Have persistent sore spots? ..... Y N
- Have lumps/bumps in head/neck? ..... Y N
- Feel a constant lump in throat? ..... Y N
- Want a saliva test for HPV risk? ..... Y N

## Function/Bite/TMJ Dysfunction:

**Do you:**

- Have missing teeth (other than wisdom)? ..... Y N
- Have chewing discomfort? ..... Y N
- Hear sounds in your jaw joints? ..... Y N
- Have frequent headaches? ..... Y N
- Have frequent jaw/facial pain? ..... Y N
- Previous treatment for TMJ? ..... Y N
  - If yes, when?
- Wear removable dentures/partial dentures? ..... Y N
  - If so, are they comfortable and well-fitting? ..... Y N

## Cancer:

**Do you:**

- Have cancer diagnosis/history? ..... Y N
  - Type:
- Current Treatment:
- Suspect/fear cancer in your body currently? ..... Y N
- Have risk factors for specific cancer? ..... Y N

### PreDiabetes and Diabetes:

**Do (Are) you:**

Have a diabetes/prediabetes diagnosis?..... Y N  
 Type I     Type II     Gestational  
 Take medications for Diabetes? ..... Y N  
 Take medications for Hypertension? ..... Y N  
 More than 10% above ideal body weight?..... Y N  
 Have waist circumference over 35"(women) or 40" (men)?..... Y N  
 Have biologic family with diabetes?..... Y N  
 Have bleeding gums when brushing/flossing? ..... Y N

### Brain Health:

**Have (Do) you?**

Been diagnosed with Depression?..... Y N  
 Feel sad, anxious, energy depleted?..... Y N  
 Lost interest in activities that brought you happiness? ..... Y N  
 Been diagnosed with Dementia?..... Y N  
 Experience "brain fog"? ..... Y N  
 Forget names or words?..... Y N  
 Frequently forget location of keys/phone/places/ directions? ..... Y N

### Other Organ Dysfunction:

**Any treatment for diseases of:**

Thyroid?..... Y N  
 Lungs?..... Y N  
 Liver?..... Y N  
 Kidneys?..... Y N  
 Uterus?..... Y N  
 Pancreas? ..... Y N  
 Brain? ..... Y N

### Women:

**Are you:**

Pregnant? ..... Y N  
 Currently nursing? ..... Y N

### Bone Health:

**Do you:**

Have osteopenia?..... Y N  
 Have osteoporosis?..... Y N  
 Have abnormal bone density test?..... Y N  
 Have history of medications for osteoporosis?..... Y N  
 Suspect a Vitamin D deficiency? ..... Y N

### Dependency/Addiction:

**Do (Are) you:**

In recovery currently? ..... Y N  
 Being treated for addiction?..... Y N  
 Consume nicotine/tobacco? ..... Y N  
     If so, what form?   
 Consume cannabis?..... Y N  
     If so, what form?   
 Chew tobacco?..... Y N  
 Depend on prescription or non-prescription drugs to:  
      Sleep     Wake     Relieve Pain  
 Consume more than three 8 oz servings of caffeine a day? ..... Y N  
 Feel addicted to sugar?..... Y N

### Joints:

**Do you have:**

Joint inflammation?..... Y N  
 Chronic pain? ..... Y N  
 Arthritis? ..... Y N  
 History of joint surgery?..... Y N  
     Type:   
     Date:   
 History of joint replacement?..... Y N  
     Type:   
     Date:

### Food and Drink:

**Do you:**

Follow a special diet? ..... Y N  
 Aspire to change your diet?..... Y N  
 Experience weight gain? ..... Y N  
 Desire a weight change? ..... Y N  
 Consume sugary foods/drinks regularly? ..... Y N  
 List regularly consumed sugary foods/drinks:

List any other beverages you consume on a regular basis:

### Pharmacology:

List all medications you're currently taking, including prescription and OTC meds, vitamins and supplements:

Are you interested in reducing amount of meds currently taking? .....Y N

### Sleep:

**Do you (or your bed partner) ever:**

- Snore? .....Y N
- Experience interruptions in breathing during sleep? .....Y N
- Have difficulty sleeping/staying asleep? .....Y N
- Feel tired or daytime fatigue? .....Y N
- Have mornings that feel awful? .....Y N
- Family history of sleep apnea? .....Y N

### Exercise:

**Do you:**

Exercise daily? .....Y N

How often:

What type(s):

Have exercise goals you hope to achieve? .....Y N

### Allergies, Food Sensitivities, and Chronic Inflammatory Conditions:

**Do you have:**

- Irritable Bowel syndrome .....Y N
- Fibromyalgia? .....Y N
- Arthritis? .....Y N
- Chronic fatigue syndrome? .....Y N
- Insulin resistance? .....Y N
- Periodontal/gum disease? .....Y N
- Allergies? .....Y N

If yes, list all:

Food Sensitivities? .....Y N

If yes, list all:

- Heart burn/acid reflux? .....Y N
- Regurgitation? .....Y N
- Weight gain? .....Y N
- GI bloating? .....Y N
- Constipation? .....Y N
- Diarrhea? .....Y N
- Red, patchy, itchy skin or itchy ears? .....Y N
- Foods that make you feel sluggish, sick or guilty? .....Y N

**Do you have any other questions or concerns that you would like to share with us today?**