GillespieDentistry
Smile With Confidence

13200 SE McGillivray
Vancouver, WA 98683
Phone: 360-892-6132
Fax: 360-892-0297
Email: team@gillespiedentistry.com

Dental History

Your answers to the following questions will allow Dr. Gillespie to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and are kept confidential.

1. Why have you come to the dentist today? _____
2. Date of your last dental appointment? _____
3. Did you bring with you any previous records today (i.e. xrays, periodontal chartings, etc.)?
   If not, can we request your previous records from your last office? Y☐ N☐
   Previous office/Dr. Name and address: _____
4. Have you ever had any serious trouble associated with previous care? Y☐ N☐
   If so, please explain: _____
5. Are you apprehensive/anxious about dental treatment? Y☐ N☐
6. On a scale of 1-10 (10 the highest), how would you rate your anxiety level at the dentist? _____
7. Do you have any history of having periodontal disease? Y☐ N☐
   What was the interval for your previous cleaning schedule (i.e. 6 mos, 4 mos, 3 mos, etc.)? _____
   Have you ever had a "deep cleaning," and if so, how recently? Y☐ N☐ Date: _____

Do you have or have you recently had any of the following:

MOUTH

Bleeding/sore gums	Y☐ N☐	Unpleasant taste/bad breath	Y☑ N☐
Burning tongue/Lips	Y☐ N☐	Frequent blisters, Lips, Mouth	Y☑ N☐
Dry mouth	Y☐ N☐	Difficulty swallowing	Y☐ N☐
Biting cheeks/Lips	Y☐ N☐	Ortho treatment/Braces	Y☐ N☐
		Date: _____	

TEETH:

Loose teeth	Y☐ N☐	Temperature sensitivity (hot/cold)	Y☐ N☐
Sensitivity to sweets	Y☐ N☐	Pressure/biting sensitivity	Y☐ N☐
Difficulty chewing	Y☐ N☐	Shifting in bite	Y☐ N☐
Implants	Y☐ N☐	Fixed Bridge(s)	Y☐ N☐
Partial/Denture	Y☐ N☐	Day/Night guard	Y☐ N☐

TMJ

Pain	Y☐ N☐	Clicking/popping/grinding noise	Y☐ N☐
Locking open/closed	Y☐ N☐	Clenching/teeth grinding habit	Y☐ N☐

Homecare routine. Do you use the following:

Electric toothbrush	Y☐ N☐	Floss/oral irrigator	Y☐ N☐
Antiseptic rinse	Y☐ N☐	Fluoride toothpaste	Y☐ N☐
Rx fluoride toothpaste	Y☐ N☐	What type of drinking water (i.e. tap, well, bottled, etc.)	
		_____	

On a scale of 1-5 (5 being the highest), how would you rate your smile? _____

If you had a magic wand, what would you change about your mouth/smile? _____

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Medical History

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Primary Care Physician: Name: _____ Phone: _____
Location: _____

Other Physicians/Specialty: Name: _____ Phone: _____
Location: _____

On a scale of 1-10 (10 the highest), how would you rate your current level of health? _____

HEART
Heart murmur Y☐ N☐
Heart valve problem Y☐ N☐
Heart surgery Y☐ N☐
Type: _____
Date: _____
Pacemaker Y☐ N☐
Rheumatic Heart Valve Y☐ N☐
Artificial Heart Valve Y☐ N☐
High blood pressure Y☐ N☐
High cholesterol Y☐ N☐

BLOOD
Easy bruising Y☐ N☐
Frequent nose bleeds Y☐ N☐
Abnormal bleeding Y☐ N☐
Blood disease (anemia) Y☐ N☐
Kidney disease Y☐ N☐

ALLERGY
Hay fever/seasonal Y☐ N☐
Sinus problems Y☐ N☐
Skin rashes Y☐ N☐
Asthma Y☐ N☐
Ear congestion Y☐ N☐

INTESTINAL
Ulcers Y☐ N☐
Weight gain/loss Y☐ N☐
Special diet Y☐ N☐
Kidney/bladder issues Y☐ N☐

SKELETAL/JOINT
Osteoporosis Y☐ N☐
Arthritis Y☐ N☐
If yes, where: _____
Back/neck pain Y☐ N☐
If yes, why (i.e. car accident, etc.)
_____
Joint replacement Y☐ N☐
If yes, where & when? _____
_____

NERVE
Bell's Palsy Y☐ N☐
Trigeminal Neuralgia Y☐ N☐
ALS (Lou Gehrig's) Y☐ N☐
Anxiety Issues Y☐ N☐
Other (please list): _____

AUTOIMMUNE
Diabetes Y☐ N☐
If yes, type I or II _____
If yes, what is your HA1C#
& date last checked: _____
Other, please list: _____
_____

WOMEN
Menopause Y☐ N☐
Taking contraceptives/
hormones Y☐ N☐
Pregnant Y☐ N☐
If yes, due date: _____
Breastfeeding Y☐ N☐

OTHER/MISC
Smoking Y☐ N☐
If yes, how much _____
for how long _____
Ever quit before, if so when?
_____
Interested in quitting Y☐ N☐

Chew/Smokeless Tobacco Y☐ N☐
Alcohol abuse Y☐ N☐
Chemical dependency Y☐ N☐
Hepatitis Y☐ N☐
HIV+/ AIDS Y☐ N☐
Herpes or other STD Y☐ N☐
Stroke Y☐ N☐
Headaches Y☐ N☐
If yes, how often? _____
Cancer Y☐ N☐
If yes, what kind _____
Date diagnosed _____
In remission? Y☐ N☐
Chemo/radiation Y☐ N☐
Respiratory disease Y☐ N☐
Ear Congestion Y☐ N☐
Tinnitus (ringing in ears) Y☐ N☐
Fainting/seizures Y☐ N☐
If yes, why? _____
Hyper/hypothyroidism Y☐ N☐
Swollen glands? Y☐ N☐
If yes, where? _____
If taking a blood thinning medication, what is your INR# & date last checked:
_____

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SLEEP

Sleep disorders are often undiagnosed and have potentially serious medical and quality of life consequences. We treat mild/moderate cases of sleep apnea here in our office with an alternative to the traditional sole-use of a CPAP machine.

1. Do you snore noticeable on most nights? Y☐ N☐
2. Are you bothered by excessive daytime sleepiness? Y☐ N☐
3. Has it ever been reported that you stop breathing or gasp when you sleep? Y☐ N☐
4. Have you ever had a sleep study or be recommended that you have one? Y☐ N☐
   If yes, please specify date and location of the test: _____
5. Do you have a CPAP? Y☐ N☐
   If yes, do you wear it on a regular basis? Since when? _____

Do you have any health problems that were not listed above and/or need further clarifications? If yes, explain:

MEDICATIONS

Do you require antibiotic pre-medication before dental visits? Y☐ N☐
If yes, please list the antibiotic used and reason for use _____

Please list all prescribed medications, over-the-counter medications, and supplements/herbals/homeopathics that you are currently taking and list the reason next to it:

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ALLERGY INFORMATION

Do you have, or have you had in the past, an adverse reaction to any of the following:

Penicillin	Y☐ N☐	Acetaminophen	Y☐ N☐
Opiates/narcotics	Y☐ N☐	Other antibiotics	Y☐ N☐
Sulfa drugs	Y☐ N☐	Latex/rubber dam	Y☐ N☐
Aspirin	Y☐ N☐	Local anesthetic (Novocaine)	Y☐ N☐
Ibuprofen	Y☐ N☐	Artificial Flavors	Y☐ N☐

Please list all medications/foods/environmental factors/etc. that you are allergic to. Please be specific:

To the best of my knowledge, all of the preceding answers are correct and current. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X _____ Date: _____
(Signature of patient, parent or legal guardian)

MEDICAL UPDATES

Date:	Changes/exceptions:	Patient Signature:
_____	_____ [ ] none	_____
_____	_____ [ ] none	_____
_____	_____ [ ] none	_____
_____	_____ [ ] none	_____
_____	_____ [ ] none	_____