HEALTH HISTORY

Patient name____Date:____________

Your current physical health is good fair poor Date of your last medical examination ______________

Are you currently under the care of a Physician? YES/ NO

If yes, why? ____

Physician's name: ______________________________Phone ( )_______________

What operations have you had? ____

Please list those medications (prescription or over the counter, including aspirin) you regularly take:

____

Check if you are allergic to any of the following:
____ Aspirin ____Penicillin ____Latex ____Codeine ____Sedatives ____Jewelry/Metals____Dental anesthetics____Eggs
____Sulfa Drugs ____Erythromycin ____Other: _____________________________________

Check if you have ever had any serious illness or conditions such as:

____Hepatitis	____Heart Disease	____Arthritis	____Tumors	____Sickle Cell Disease
____Rheumatic Fever	____High Blood Pressure	____Thyroid Condition	____Hives	____Fainting
____Heart Murmur	____Lung Disease	____Osteoporosis	____Asthma	____Artificial Heart
____Kidney Disease	____Stroke	____Tuberculosis	____Glaucoma	____Allergies
____Epilepsy	____Diabetes	____Chemotherapy	____Emphysema	____Hay Fever
____Sinus Trouble	____Valve Pacemaker	____Blood Transfusion	____Ulcers	____Liver Disease
____Anxiety	____Mitro Valve Prolapse	____Restricted Diet	____ Artificial Joints	____Cold Sores

____Neurological Disorders Other: ____

YES NO Have you ever received radiation for cancer treatment to the head or neck area?
YES NO Do you pre medicate with antibiotics before dental work?
YES NO Are you asthmatic? If so, what medication do you take? ______________________
YES NO Do you have chest pain or shortness of breath on exertion?
YES NO Do your ankles swell?
YES NO Do you have or have you ever had any heart trouble? (Heart Attack, Heart Failure, Etc.)
YES NO Have you had psychiatric treatment?
YES NO Do you smoke? If yes, how many per day? __________ How long have you smoked? __________
YES NO Do you have a cold, cough, or chest congestion?
YES NO Do you have a regular cough?
YES NO Are you now, or have you ever taken any recreational drugs (cocaine, marijuana, etc)?
YES NO Have you ever tested positive with the HIV or hepatitis virus?
YES NO Do you wear contact lenses?
YES NO Have you ever taken any medications for weight control? Phen-Phen or other?
YES NO Do you have a bleeding disorder (i.e. Hemophilia)
YES NO Do you or have you taken any medication to treat osteoporosis? Fosamax or any other Bisphosphonates?

FOR FEMALE PATIENTS ONLY:
YES NO Are you pregnant? If so, which trimester? __________
YES NO Are you on birth control pills?
YES NO Are you nursing?

I AFFIRM THAT THE INFORMATION I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES.

SIGNATURE_______________________________DATE____________________
(If under 18 years of age, parent's signature is required)

DENTIST SIGNATURE_______________________DATE____________________

DENTAL HISTORY

Patient Name	Date	Medical Alert(s)

What is the reason for your visit today?

____

____

Date of Last Dental Visit__________ **Last Dental Cleaning** __________ **Last Full Mouth X-rays** __________

What was done at your last dental visit? __________

Previous Dentist's Name __________Telephone __________

Address __________

How often do you have dental examinations? __________

How often do you brush your teeth? __________ How often do you floss?__________

Have you ever used or are you currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) __________

Do you have any dental problems now Yes No If yes, please describe: __________

Are any teeth sensitive to:

Hot or cold? ....Yes No

Sweets? ....Yes No

Biting or Chewing? ....Yes No

Have you noticed any mouth odors or bad tastes? ....Yes No

Do you frequently get cold sores, blisters, or other oral lesions? ...... Yes No

Do your gums bleed or hurt? ....Yes No

Have your parents experienced gum disease or tooth loss? ....Yes No

Have you noticed any loose teeth or change in your bite? ....Yes No

Does food tend to become caught in between your teeth? ....Yes No

If yes, where __________

Do you:

Clench or grind your teeth while awake or asleep? ....Yes No

Bite your lips or cheeks regularly? ....Yes No

Hold foreign objects with your teeth? (pencils, pipes, etc.) ....Yes No

Mouth breathe while awake or asleep? ....Yes No

Snore or have any other sleeping disorders? .... Yes No

Smoke/chew tobacco or use other tobacco products? ....Yes No

Have you ever had:

Orthodontic treatment? .... Yes No

Oral Surgery? .... Yes No

Periodontal Treatment? .... Yes No

Your teeth ground or the bite adjusted? .... Yes No

A bite plate or mouth guard? .... Yes No

A serious injury to the mouth or head? .... Yes No

Please describe, including cause __________

Have you experienced:

Clicking or popping of the jaw? .... Yes No

Pain? (joint, ear, side of face).................... Yes No

Difficulty in opening or closing the mouth?........... Yes No

Difficulty in chewing on either side of the mouth?...Yes No

Headaches, neck aches or shoulder aches? ....Yes No

Tired jaws, especially in the morning? ....Yes No

Are you satisfied with your teeth's appearance? .. Yes No

Would you like to replace your silver fillings?..........Yes No

Would you like to keep all of your teeth? ....Yes No

Do you feel nervous about having dental treatment? ....Yes No

Please describe__________

Have you ever had an upsetting dental experience? ....Yes No

Please describe __________

Is there anything else about having dental treatment that you would like us to know? Yes No If yes, please describe __________

____