Health History

(Confidential)

NAME_____ BIRTH DATE _____ TODAY'S DATE_____

Dental History

1. Reason for today's visit? (Chief complaint):_____
2. Name of Previous Dentist and Location:: _____
3. When was you last dental visit?_____ What treatment was performed? _____
4. When was you last cleaning?_____ X-Rays? _____

	YES	NO
5. Do your gums bleed?	☐	☐
6. Are your teeth sensitive? To what?_____	☐	☐
7. Do you experience:		
a.) swollen gums	☐	☐
b.) loosening of teeth	☐	☐
c.) puss, foul odor	☐	☐
d.) bitter taste	☐	☐
e.) bad breath (halitosis)	☐	☐
f.) sores or lumps in/near your mouth	☐	☐
8. Do you have jaw joint (TMJ/TMD) problems?	☐	☐
9. Have you ever hand any difficult extractions in the past or prolonged bleeding following extractions?	☐	☐
10. Have you had:		
a.) gum treatments of gum surgery?	☐	☐
b.) Oral surgery/wisdom teeth removed	☐	☐
c.) Orthodontic treatment (braces)?	☐	☐
d.) Bite adjustments?	☐	☐
e.) Nitrous oxide (laughing gas)?	☐	☐

	YES	NO
11. Do you wear dentures or partials? If yes, date of placement_____	☐	☐
12. Do you:		
a.) clench or grind you teeth while awake or asleep?	☐	☐
b.) wear (or have worn) a night guard or bite plane appliance?	☐	☐
13 Are you satisfied with the appearance of your smile?	☐	☐
14. If no, what specifically would you change? Explain: _____		
15. Are you apprehensive about receiving treatment?	☐	☐
16. What do you dislike most about dental treatment? _____	☐	☐

If you are currently experiencing pain or discomfort (i.e. toothache) how would you describe it?

☐ sharp ☐ dull (ache) ☐ throbbing ☐ hot sensitive ☐ cold sensitive ☐ intermittent (comes and goes)

☐ spontaneous ☐ constant ☐ sensitive to chewing pressure ☐ relieved by cold liquids

☐ wakes you up at night ☐ relieved with pain medication ☐ tenderness ☐ swelling of gum or jaw

☐ puss discharge or bitter taste ☐ comes about after eating sweet or sour foods or normal foods

☐ when hot/cold sensitive, discomfort lasts less than 30 seconds or ☐ one-half hour or longer

☐ other_____

Medical History

(Confidential)

Your Medical Doctor's Name: _____ Office Phone _____ Date of last exam _____

1. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? YES ☐ NO ☐
   If yes, please explain: _____
2. List any medications (including non-prescription) you are taking (including dosages): _____
   _____
   _____
3. Have there been any changes in your health within the past year? YES ☐ NO ☐
   Explain: _____

	YES	NO
4. Do you bruise easily or have prolonged bleeding?	☐	☐
5. Have you ever required a blood transfusion?	☐	☐
6. Have you needed pre-medication with antibiotics? (other than for a food infections)	☐	☐

	YES	NO
7. Have you had a recent weight loss?	☐	☐
8. Have you ever taken Fen-phen for weight loss?	☐	☐
9. Do you use tobacco?	☐	☐
10. Last Blood Pressure Reading_____ Over_____		

Women Only:

Are you: a.) pregnant or think you may be?	☐	☐
b.) nursing?	☐	☐
c.) taking birth control pills?	☐	☐

Are you allergic to or have you had reactions to:

	YES	NO
1. Local anesthetics like novocaine?	☐	☐
2. Penicillin/Amoxicillin?	☐	☐
3. Ceclor Ketflex?	☐	☐
4. Tetracycline?	☐	☐
5. Eyrthromycin?	☐	☐
6. Azithromycin/Clarithromycin?	☐	☐
7. Clindamycin?	☐	☐
8. Codeine?	☐	☐
9. Aspirin?	☐	☐
10. Tylenol?	☐	☐
11. Ibuprofen?	☐	☐
12. **Other?**_____		

Do you have or have you had any of the following? Please complete all three columns.

	YES	NO
Heart disease	☐	☐
Heart attack	☐	☐
Chest pains (angina)	☐	☐
Irregular heartbeat	☐	☐
Heart Murmur	☐	☐
Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐
Congenital heart defect	☐	☐
Congestive heart failure	☐	☐
Bypass surgery	☐	☐
Cardiac pacemaker	☐	☐
Stroke	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Blood disorders	☐	☐
Anemia	☐	☐

Continue to Column 2

	YES	NO
Leukemia	☐	☐
Dizziness	☐	☐
Fainting/Convulsions	☐	☐
Epilepsy/Seizures	☐	☐
Diabetes (I or II)	☐	☐
Liver disease	☐	☐
Jaundice	☐	☐
Hepatitis A, B, C	☐	☐
Respiratory problems	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Persistent cough	☐	☐
Cough up blood	☐	☐
Tuberculosis	☐	☐
Night sweats	☐	☐
Allergies	☐	☐
Sinus	☐	☐
Glaucoma	☐	☐

Continue to column 3

	YES	NO
Stomach/bowel disorder	☐	☐
Ulcer	☐	☐
Thyroid	☐	☐
Kidney disease	☐	☐
Kidney infection/stones	☐	☐
Cortisone medication	☐	☐
Cancer	☐	☐
Tumor	☐	☐
Radiation/chemotherapy	☐	☐
Arthritis	☐	☐
Joint replacement/implant	☐	☐
AIDS or HIV infection	☐	☐
Sexually trans. diseases	☐	☐
Fever blisters	☐	☐
Canker sores	☐	☐
Psychiatric treatment	☐	☐
Nervousness	☐	☐
Other_____	☐	☐

Do you have any disease, condition or problem not listed above? ☐ Yes ☐ No Explain: _____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X _____ X _____

Signature of patient, parent or guardian Date