

# Health History

(Confidential)

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

## Dental History

- Reason for today's visit? (Chief complaint): \_\_\_\_\_
- Name of Previous Dentist and Location: \_\_\_\_\_
- When was your last dental visit? \_\_\_\_\_ What treatment was performed? \_\_\_\_\_
- When was your last cleaning? \_\_\_\_\_ X-Rays? \_\_\_\_\_

- |                                                                                                               | YES                      | NO                       |                                                                   | YES                      | NO                       |
|---------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|-------------------------------------------------------------------|--------------------------|--------------------------|
| 5. Do your gums bleed?                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | 11. Do you wear dentures or partials?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are your teeth sensitive?<br>To what? _____                                                                | <input type="checkbox"/> | <input type="checkbox"/> | If yes, date of placement _____                                   |                          |                          |
| 7. Do you experience:                                                                                         |                          |                          | 12. Do you:                                                       |                          |                          |
| a.) swollen gums                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | a.) clench or grind your teeth while awake<br>or asleep?          | <input type="checkbox"/> | <input type="checkbox"/> |
| b.) loosening of teeth                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | b.) wear (or have worn) a night guard or<br>bite plane appliance? | <input type="checkbox"/> | <input type="checkbox"/> |
| c.) pus, foul odor                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | 13. Are you satisfied with the appearance of<br>your smile?       | <input type="checkbox"/> | <input type="checkbox"/> |
| d.) bitter taste                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | 14. If no, what specifically would you change?<br>Explain: _____  |                          |                          |
| e.) bad breath (halitosis)                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | 15. Are you apprehensive about receiving<br>treatment?            | <input type="checkbox"/> | <input type="checkbox"/> |
| f.) sores or lumps in/near your mouth                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | 16. What do you dislike most about<br>dental treatment? _____     |                          |                          |
| 8. Do you have jaw joint (TMJ/TMD)<br>problems?                                                               | <input type="checkbox"/> | <input type="checkbox"/> |                                                                   |                          |                          |
| 9. Have you ever had any difficult<br>extractions in the past or prolonged<br>bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |                                                                   |                          |                          |
| 10. Have you had:                                                                                             |                          |                          |                                                                   |                          |                          |
| a.) gum treatments or gum surgery?                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |                                                                   |                          |                          |
| b.) Oral surgery/wisdom teeth<br>removed?                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |                                                                   |                          |                          |
| c.) Orthodontic treatment (braces)?                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |                                                                   |                          |                          |
| d.) Bite adjustments?                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |                                                                   |                          |                          |
| e.) Nitrous oxide (laughing gas)?                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |                                                                   |                          |                          |

### If you are currently experiencing pain or discomfort (ie. 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   pus 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		YES	NO
4. Do you bruise easily or have prolonged bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	7. Have you had a recent weight loss?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever required a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	8. Have you ever take Fen-Phen for weight loss?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you needed pre-medication with antibiotics?(other than for a tooth infection)	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
			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		YES	NO
1. Local anesthetics like novocaine?	<input type="checkbox"/>	<input type="checkbox"/>	7. Clindamycin?	<input type="checkbox"/>	<input type="checkbox"/>
2. Penicillin/Amoxicillin?	<input type="checkbox"/>	<input type="checkbox"/>	8. Codeine?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ceclor/Keflex?	<input type="checkbox"/>	<input type="checkbox"/>	9. Aspirin/Tylenol?	<input type="checkbox"/>	<input type="checkbox"/>
4. Tetracycline?	<input type="checkbox"/>	<input type="checkbox"/>	10. Ibuprofen?	<input type="checkbox"/>	<input type="checkbox"/>
5. Erythromycin?	<input type="checkbox"/>	<input type="checkbox"/>	11. Latex?	<input type="checkbox"/>	<input type="checkbox"/>
6. Azithromycin/Clarithromycin?	<input type="checkbox"/>	<input type="checkbox"/>	12. <b>Other?</b> _____		

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

	YES	NO		YES	NO		YES	NO
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/bowel disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains (angina)	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (I or II)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection/stones	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone medication	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A,B,C	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>	Radiation/Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Bypass surgery	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement/Implant	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Trans. Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Canker sores	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Sinus	<input type="checkbox"/>	<input type="checkbox"/>			

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

Signature of patient, parent, or guardian

X

Date