

# Health History

Name \_\_\_\_\_

Date \_\_\_\_\_

## DENTAL

- |   |     |    |
|---|-----|----|
| 1. Are you having any discomfort at this time? .....  | Yes | No |
| 2. Have you ever had any serious trouble associated with previous dental treatment? .....           | Yes | No |
| If so, explain _____  |     |    |
| 3. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____ |     |    |
| 4. Date of last dental visit _____  |     |    |
| 5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?        | Yes | No |
| If so, when? _____  |     |    |
| 6. If you could change anything about your smile, what would it be? _____                           |     |    |
| _____   |     |    |

7. Do you have or have you ever had any of the following:

### Mouth

- |  |     |    |
|--|-----|----|
| Bleeding Sore Gums .....                 | Yes | No |
| Unpleasant taste / bad breath .....      | Yes | No |
| Burning tongue / lips .....              | Yes | No |
| Frequent blisters, lips / mouth .....    | Yes | No |
| Cold Sores .....                         | Yes | No |
| Swelling / lumps / ulcers in mouth ..... | Yes | No |
| Ortho treatment (braces) .....           | Yes | No |
| Biting cheeks / lips .....               | Yes | No |
| Clicking / popping / pain in jaw .....   | Yes | No |
| Difficulty opening or closing jaw .....  | Yes | No |

### Teeth

- |                            |     |    |
|----------------------------|-----|----|
| Loose teeth .....          | Yes | No |
| Sensitive to hot .....     | Yes | No |
| Sensitive to cold .....    | Yes | No |
| Sensitive to sweets .....  | Yes | No |
| Sensitive to biting .....  | Yes | No |
| Food impaction .....       | Yes | No |
| Clenching / grinding ..... | Yes | No |
| If so, when _____          |     |    |
| Shifting in bite .....     | Yes | No |
| Do you use the following:  |     |    |
| Brush .....                | Yes | No |
| Dental Floss .....         | Yes | No |
| Fluoride Rinse .....       | Yes | No |

## MEDICAL

- |   |     |    |
|---|-----|----|
| 1. My last physical examination was on _____                        |     |    |
| 2. Are you under the care of a physician? .....                     | Yes | No |
| If so, what is the condition being treated? _____                   |     |    |
| 3. Are you taking any medications, herbs or vitamins? .....         | Yes | No |
| If so, state drug, herb or vitamin name, dosage and frequency _____ |     |    |
| _____   |     |    |
| 4. The name and phone# of my physician is _____                     |     |    |
| _____   |     |    |

Are you allergic or have you adversely reacted to:

- |   |     |    |
|---|-----|----|
| Local anesthetics .....                             | Yes | No |
| Penicillin or other antibiotics .....               | Yes | No |
| Sulfa drugs .....                                   | Yes | No |
|   |     |    |
| Antidepressants, sedatives, or sleeping pills ..... | Yes | No |
| Aspirin, Advil, Alleve, Tylenol .....               | Yes | No |
| Latex .....   | Yes | No |
| Codeine or other narcotics .....                    | Yes | No |
| Fen-Phen .....                                      | Yes | No |
| Other _____   | Yes | No |

5. Do you have any or have you had any of the following:

- |  |     |    |
|--|-----|----|
| Heart attack, heart trouble .....                | Yes | No |
| Angina Pectoris .....                            | Yes | No |
| Arteriosclerosis stroke .....                    | Yes | No |
| High/low blood pressure .....                    | Yes | No |
| Rheumatic fever or rheumatic heart disease ..... | Yes | No |
| Congenital heart disease .....                   | Yes | No |
| Heart murmur .....                               | Yes | No |
| Do you have chest pains upon exertion .....      | Yes | No |
| Artificial or replacement valves .....           | Yes | No |
| Pacemaker .....                                  | Yes | No |
| Thyroid disease .....                            | Yes | No |
| Bruise easily .....                              | Yes | No |
| Blood transfusion .....                          | Yes | No |
| Alcohol or Drug addiction .....                  | Yes | No |

- |   |     |    |
|---|-----|----|
| Glaucoma .....  | Yes | No |
| Asthma or hay fever, Sinus troubles, Allergies .....    | Yes | No |
| Hives or skin rash .....                                | Yes | No |
| Epilepsy, fainting spells or seizures .....             | Yes | No |
| Diabetes .....  | Yes | No |
| Hepatitis, jaundice, or liver disease .....             | Yes | No |
| Arthritis or inflammatory, rheumatism .....             | Yes | No |
| Artificial or replacement joints, prosthetic pins ..... | Yes | No |
| Ulcers or stomach disorders (colitis) .....             | Yes | No |
| Kidney trouble .....                                    | Yes | No |
| Tuberculosis .....                                      | Yes | No |
| Persistent cough or cough up blood .....                | Yes | No |
| Immune System disorders(including AIDS,HIV,ARC)         | Yes | No |
| Venereal Disease, Herpes .....                          | Yes | No |

- |   |     |    |
|---|-----|----|
| 6. Have you ever been hospitalized or had an operation? .....   | Yes | No |
| If so, what was the problem _____   |     |    |
| 7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? .....             | Yes | No |
| 8. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? .....                     | Yes | No |
| 9. Do you use tobacco or alcohol products? .....  | Yes | No |
| If so, how much per day and what? _____   |     |    |
| 10. Are you experiencing stress or pressure in your work or at home? .....                                    | Yes | No |
| 11. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... | Yes | No |
| If so, explain _____  |     |    |

## WOMEN

- |   |     |    |
|---|-----|----|
| 1. Are you pregnant? .....                                | Yes | No |
| 2. Are you taking birth control or hormone therapy? ..... | Yes | No |

**To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the Dentist at the next appointment.**

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_

Date \_\_\_\_\_