HEALTH HISTORY

Name____ Date___________________________________

DENTAL

Are you having any discomfort at this time? . . . . . Yes No
Have you had any serious problems associated with dental treatment? . . . . . Yes No
Explain____
Does dental treatment make you nervous? No____ Slightly____ Moderately____ Extremely____
Date of last dental visit?__________________________________
Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Date__________________ Yes No
If you could change anything about your smile, what would it be? __________________________________

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

Mouth			Teeth		
Bleeding Sore Gums	Yes	No	Loose teeth	Yes	No
Unpleasant taste / bad breath	Yes	No	Sensitive to hot	Yes	No
Burning tongue / lips	Yes	No	Sensitive to cold	Yes	No
Frequent mouth ulcers/cold sores	Yes	No	Sensitive to sweets	Yes	No
Dry mouth	Yes	No	Sensitive to biting	Yes	No
Ortho treatment (braces)	Yes	No	Clenching/grinding	Yes	No
Clicking / popping / pain in jaw	Yes	No	Do you use the following:		
Difficulty opening or closing jaw	Yes	No	Brush	Yes	No
TMJ problems/surgery	Yes	No	Dental Floss	Yes	No
Explain ____________________			Fluoride Rinse	Yes	No

MEDICAL

Physician's Name___________________________ Phone Number___________________________

Please list all **medications** you are currently taking including over the counter meds and vitamins. List additional medications on back of page.

Med:__________________**Condition**_______________ **Med:**__________________**Condition**_______________

Med:__________________**Condition**_______________ **Med:**__________________**Condition**_______________

Are you allergic or had an adverse reaction to:

Local anesthetics (Novocaine)	Yes	No	Latex	Yes	No
Codeine/Narcotics	Yes	No	Metals(Nickel)/Plastics	Yes	No
Penicillin	Yes	No	Ibuprofen/Advil/Aleve/NSAIDS	Yes	No
Sulfa drugs or other antibiotics	Yes	No	Aspirin	Yes	No
			Other____________________		

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

Heart attack, Heart Disease	Yes	No	Glaucoma	Yes	No
Congenital Heart Disease	Yes	No	Asthma or hay fever, sinus troubles, allergies	Yes	No
Angina Pectoris	Yes	No	Hives or skin rash	Yes	No
Stroke/Arteriosclerosis	Yes	No	Epilepsy, fainting spells or seizures	Yes	No
High/low blood pressure	Yes	No	Diabetes	Yes	No
Pacemaker	Yes	No	Hepatitis, jaundice, or liver disease	Yes	No
Artificial or replacement valves	Yes	No	Arthritis or inflammatory rheumatism	Yes	No
Osteoporosis	Yes	No	Artificial or replacement joints, prosthetic pins	Yes	No
Thyroid disease	Yes	No	Ulcers or stomach disorders (colitis)	Yes	No
Anemia	Yes	No	Kidney trouble	Yes	No
Blood Thinners	Yes	No	Tuberculosis	Yes	No
Presence of a stent related to coagulation therapy	Yes	No	Immune system disorders (including AIDS,HIV, ARC)	Yes	No
			Venereal Disease, Herpes	Yes	No

Have you ever been hospitalized or had an operation? . . . . . Yes No
Explain____
Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? . . . . . Yes No
Have you had surgery, radiation or chemotherapy for a tumor, growth, cancer or other condition? . . . . . Yes No
Are you currently being treated with Biophosphonates such as Fosamax, Boniva, or Actonel? . . . . . Yes No
Do you use tobacco or alcohol products? . . . . . Yes No
If so, how much per day and what? ______________________________________
Are you experiencing stress or pressure in your work or at home? . . . . . Yes No
Do you have any disease, condition, or problem not listed above that you think we should know about? . . . . . Yes No
Explain____

WOMEN

Are you pregnant? . . . . . Yes No
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