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)? ☐ Yes ☐ No
Date: _____
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 _____

Pharmacy Info (List name, phone#, address):
Please list all **medications** you are currently taking including over the counter meds and vitamins. List additional medications on end of page.

Med: _____ **Condition:** **Med:** _____ **Condition:**
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 Initials Date Dentist Signature Date

Please email completed form to office@wjscottdds.com