

Health History

Name: _____ Birthdate: ____/____/____

1 Patient Information

Although dentists primarily treat the mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important correlation with the dentistry that you will be receiving. Thank you for answering the following questions.

Your current physical health is: Excellent Good Fair Poor

Physician's name: _____ Office #: _____ Last physical exam: ____/____

If currently under a physician's care, explain why: _____

Drug - Reason(s) Drug - Reason(s)

List all prescription / non-prescription drugs you are taking and the reason(s) for each:

Do you have or have you ever had any of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Anesthetic Allergy | <input type="checkbox"/> Flu / Common Cold | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Angina / Heart Pain | <input type="checkbox"/> Fainting / Dizziness | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety Attacks | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis / Rheumatism | <input type="checkbox"/> Headaches (Chronic) | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Aspirin Allergy | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Birth Control Pills (Now) | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pregnant / Nursing (Now) |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Heart Valve / Shunt | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis C/D | <input type="checkbox"/> Smoker – Heavy x__ yrs |
| <input type="checkbox"/> Chemotherapy / Radiation | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Smoker – Light x__ yrs |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Smoker –Moderate x__ yrs |
| <input type="checkbox"/> Coumadin/ Warfarin | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes - Insulin | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Tobacco Chewing |
| <input type="checkbox"/> Diabetes – Non-Insulin | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Drug / Alcohol Abuse | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Wheelchair / Transport |

Other Condition(s): _____

Other Drug Allergies: _____

Dental History

Reason for Today's Visit: Exam/Cleaning Consultation Emergency

Previous Dentist Name: _____ City: _____ State: _____ Satisfied? Yes No

Date of Last Visit: ____/____/____

Specific Dental Problem(s): _____

Current Health of Teeth: Good Fair Poor Do Not Know

Current Health of Gums: Good Fair Poor Do Not Know

Do you have any of the following?

- | | | |
|---|--|---------------------------------|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Wisdom Tooth Pain | Teeth Sensitive To: |
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Chipper, Cracked, Broken Teeth | <input type="checkbox"/> Hot |
| <input type="checkbox"/> Sore Gums | <input type="checkbox"/> Food Catches between Teeth | <input type="checkbox"/> Cold |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Crowded, Tipped, Shifted Teeth | <input type="checkbox"/> Air |
| <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Clench or Grind your Teeth | <input type="checkbox"/> Sweets |
| <input type="checkbox"/> Discolored Teeth | <input type="checkbox"/> Jaw Joint Clicking, Popping, Pain | <input type="checkbox"/> Biting |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Poor Fitting Dentures | |

(Please Circle)

- Y N Dental exams on a regular basis? How often? _____
- Y N Cleanings on a regular basis? How often? _____
- Y N Brush on a regular basis? How often? _____
- Y N Floss on a regular basis? How often? _____
- Y N Ever had braces? When? _____
- Y N Gum treatment or surgery? When? _____
- Y N Sores or lumps in mouth? Where specifically? _____
- Y N Feel nervous about dental treatment? Please explain: _____
- Y N Complications with previous dental treatment? Please explain: _____
- Y N Questions or concerns? Please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that this information will be held in strict confidence and it is my responsibility to inform the dental office of any changes in my medical status.

X _____ / ____ / ____
Signature of Patient, Parent or Guardian