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:____

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

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

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

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

[ ] Cavities
[ ] Toothache
[ ] Sore Gums
[ ] Bleeding Gums
[ ] Loose Teeth
[ ] Discolored Teeth
[ ] Bad Breath

[ ] Wisdom Tooth Pain
[ ] Chipped, Cracked, Broken Teeth
[ ] Food Catches between Teeth
[ ] Crowded, Tipped, Shifted Teeth
[ ] Clench or Grind your Teeth
[ ] Jaw Joint Clicking, Popping, Pain
[ ]Poor Fitting Dentures

Teeth Sensitive To:
[ ] Hot
[ ] Cold
[ ] Air
[ ] Sweets
[ ]Biting

(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