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**	Glaucoma	**Yes**	**No**
Angina Pectoris	**Yes**	**No**	Asthma or hay fever, Sinus troubles, Allergies	**Yes**	**No**
Arteriosclerosis stroke	**Yes**	**No**	Hives or skin rash	**Yes**	**No**
High/low blood pressure	**Yes**	**No**	Epilepsy, fainting spells or seizures	**Yes**	**No**
Congenital heart disease	**Yes**	**No**	Diabetes	**Yes**	**No**
Do you have chest pains upon exertion	**Yes**	**No**	Hepatitis, jaundice, or liver disease	**Yes**	**No**
Artificial or replacement valves	**Yes**	**No**	Arthritis or inflammatory, rheumatism	**Yes**	**No**
Pacemaker	**Yes**	**No**	Artificial or replacement joints, prosthetic pins	**Yes**	**No**
Thyroid disease	**Yes**	**No**	Ulcers or stomach disorders (colitis)	**Yes**	**No**
Bruise easily	**Yes**	**No**	Kidney trouble	**Yes**	**No**
Blood transfusion	**Yes**	**No**	Tuberculosis	**Yes**	**No**
Alcohol or Drug addiction	**Yes**	**No**	Persistent cough or cough up blood	**Yes**	**No**
Presence of a stint related to coagulation therapy. . .	**Yes**	**No**	Immune System disorders(including AIDS,HIV,ARC)	**Yes**	**No**
Osteoporosis.	**Yes**	**No**	Venereal Disease, Herpes	**Yes**	**No**
Bisphosphonates, ie, Fosamax, Boniva, Actonel, etc.	**Yes**	**No**	Coumadin / Warfarin.	**Yes**	**No**

6. Have you ever been hospitalized? . . . . . **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