Health History

Name_____________________________________ Birthdate_______________________ Age____________

DENTAL HISTORY

General Dentist____ Office Phone_______________________

Specialty Dentist____ Office Phone_______________________

Why are you seeking dental treatment?____

Have you ever had any serious trouble associated with previous dental treatment?

____

Does Dental Treatment make you nervous? ___No ___Slightly ___Moderately ___Extremely

Date of your last dental visit?______________________

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?____________________

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

Bleeding, sore gums	**Y**	**N**	Loose Teeth	**Y**	**N**
Unpleasant taste/ bad breath	**Y**	**N**	Sensitive to hot	**Y**	**N**
Frequent blisters, lips/mouth	**Y**	**N**	Sensitive to cold	**Y**	**N**
Burning tongue/ lips	**Y**	**N**	Sensitive to sweets	**Y**	**N**
Swelling/ lumps in mouth	**Y**	**N**	Sensitive to biting	**Y**	**N**
Orthodontics (braces)	**Y**	**N**	Food impaction	**Y**	**N**
Biting cheeks/ lips	**Y**	**N**	Clenching/ grinding	**Y**	**N**
Clicking/ popping jaw	**Y**	**N**	Shifting of teeth	**Y**	**N**
Difficulty opening or closing jaw	**Y**	**N**	Change in bite	**Y**	**N**

MEDICAL HISTORY

Primary Care Physician__________________________________ Physician Phone______________________

Specialty Doctor____ Office Phone_________________________

Are you currently under the care of a physician? **Y** **N**

If so, what is the condition being treated?____

Have you ever been hospitalized or had a serious illness? **Y** **N**

If yes, please explain____

Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? **Y** **N**

(Women) Are you pregnant? **Y** **N** Due Date_________________________

Are you ALLERGIC to or have you had any reaction to the following?

Local anesthetics (Novocain, Lidocaine)	**Y**	**N**	Aspirin or codeine	**Y**	**N**
Barbiturates/ sedatives/ sleeping pills	**Y**	**N**	Sulfa drugs	**Y**	**N**
Antibiotics (Penicillin, Bactrim, Keflex)	**Y**	**N**	Other allergies____________________		

Are you currently taking any of the following?

Antibiotics	**Y**	**N**	Tranquilizers	**Y**	**N**
Sulfa Drugs	**Y**	**N**	Herbal supplements	**Y**	**N**
Blood Pressure Medication	**Y**	**N**	Insulin/ Diabetes medication	**Y**	**N**
Thyroid Medication	**Y**	**N**	Recreational drugs	**Y**	**N**
Cortisone/ steroids	**Y**	**N**	Digitalis/ Heart medication	**Y**	**N**
Antihistamines (allergy, cold med)	**Y**	**N**	Nitroglycerin	**Y**	**N**

Please complete reverse side →

MEDICAL HISTORY cont'd….

Please list **all medications** you are currently taking: ____

Reason for use: ____

**If you are taking more than 5 medications, please provide us with a full list on a separate sheet of paper

Vitamins/Supplements?____

Do you use tobacco in any form? **Y** **N** If so, how much?____________________

Do you use alcoholic beverages (more than 2 drinks per day)? **Y** **N** How much?____________________

Do you use any recreational drugs? **Y** **N** If so, which one(s)? How often?____________________

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

GENERAL

Tire easily, weakness	Y	N
Marked weight change	Y	N
Night sweats	Y	N
Persistent fever	Y	N

SKIN

Eruptions (rash, hives)	Y	N
Changes in skin color	Y	N

EYES

Visual change	Y	N
Glaucoma	Y	N
Vision loss	Y	N

NOSE

Frequent Nosebleeds	Y	N
Sinus problems	Y	N

THROAT

Soreness/ hoarseness	Y	N

NERVOUS SYSTEM

Stroke	Y	N
Headaches/ migraines	Y	N
Convulsions/ epilepsy	Y	N
Numbness/ tingling	Y	N
Dizziness/ fainting	Y	N
Psychiatric treatment	Y	N

RESPIRATORY

Tuberculosis	Y	N
Emphysema	Y	N
Asthma/ hay fever	Y	N
Persistent cough	Y	N
Sputum production (phlegm)	Y	N
Cough up bloody sputum	Y	N
Difficulty breathing while lying down	Y	N

ENDOCRINE

Diabetes	Y	N
Family history of Diabetes	Y	N
Thyroid condition/ goiter	Y	N

Other____________________

HEART/BLOOD VESSELS

Rheumatic fever	Y	N
Heart murmur	Y	N
Chest pain/ discomfort	Y	N
Heart attack/ trouble	Y	N
Shortness of breath	Y	N
Swelling of ankles	Y	N
High blood pressure	Y	N
Congenital heart disease	Y	N
Mitral valve prolapse	Y	N
Artificial heart valve	Y	N
Pacemaker	Y	N
Heart surgery	Y	N

Other____________________

BONE/ MUSCLES

Arthritis/ rheumatism	Y	N
Artificial joint/ limbs	Y	N

DIGESTIVE SYSTEM

Hepatitis	Y	N
Jaundice	Y	N
Ulcers	Y	N
Change in appetite	Y	N
Black, bloody or pale stools	Y	N

URINARY

Kidney disease	Y	N
Frequent urination (night)	Y	N
Burning on urination	Y	N
Urethral discharge	Y	N
Bloody urine	Y	N
Venereal disease	Y	N

BLOOD

Bruise easily	Y	N
Anemia	Y	N
Blood transfusion	Y	N

OTHERS

Eating disorder	Y	N
Radiation therapy	Y	N
Chemotherapy	Y	N
Tumors/growths	Y	N
Cancer	Y	N
HIV/AIDS	Y	N

Signature____ **Date**____________________