



Health History

Confidential

Patient's Name _____ Date of Birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important inter-relationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Check Appropriate Box:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health within the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Date of your last physical exam: _____ | | |
| 4. Physician's name: _____
Address: _____
Phone Number: _____ | | |
| 5. Have you ever been hospitalized for any surgical operation or serious illness?
Please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you taking any medicine(s) including non-prescription medicine?
If yes, what medicine(s) are you taking? _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had any abnormal bleeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever required a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing Bisphosphonates? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you or have you used controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any disease, condition or problem not listed above that you think I should know about? | <input type="checkbox"/> | <input type="checkbox"/> |

WOMEN ONLY:

- | | | |
|--|--------------------------|--------------------------|
| Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |



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ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

	YES	NO
Local anesthetics like Novocaine	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Any metals (E.G., Nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Latex/rubber	<input type="checkbox"/>	<input type="checkbox"/>

Other (please list): _____

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO		YES	NO
Rheumatic heart disease or rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Heart defect or heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement or implant	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble, heart attack, or angina	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney trouble	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Cough that produces blood	<input type="checkbox"/>	<input type="checkbox"/>
High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy (cancer, leukemia)	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart problem	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of feet, ankles, hands	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Lung or breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Mental health care	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>
Hives or skin rash	<input type="checkbox"/>	<input type="checkbox"/>	Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone treatment	<input type="checkbox"/>	<input type="checkbox"/>
Aids or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores/fever blisters	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>



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PATIENT'S DENTAL HISTORY

Reason for this visit _____ Last dental visit _____

How frequently did you visit the dentist? _____

Previous dentist (name and location) _____

Have you had a complete series of dental x-rays taken recently? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Is your drinking water fluoridated? _____

Tell us About Your Smile

	YES	NO
Are you comfortable showing your teeth when you smile?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have unsightly crowns or fillings?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel your teeth are too long or too short?	<input type="checkbox"/>	<input type="checkbox"/>
Do you like the color of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in improving the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you missing any teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any loosening teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in tooth replacements?	<input type="checkbox"/>	<input type="checkbox"/>
Do your teeth or gums hurt?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Does food tend to become caught between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had periodontal treatment (gums)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you anxious or fearful of dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
If you could change anything about your smile, what would you change?		



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HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?

	YES	NO
Clicking	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Parent/Guardian if Minor

Date