

Health History

Patient Name _____

Birth date _____ Phone # _____

Are you under the care of a Physician? yes no

Why? _____

What medications or pills are you currently taking?

What Herbs or diet supplements do you take regularly?

Are you taking medication for preventing osteoporosis?

Please list _____

Are you allergic to any medications or substances?

Aspirin Codeine Penicillin Latex Sulfa

Jewelry/Metals Other _____

Have you ever been instructed to pre-medicate with antibiotics before receiving dental care? yes no

For Women: Are you pregnant? yes no

Have you experienced the following?

	Yes	No		Yes	No
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/ Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Tx	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Any heart problem	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/ HIV	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/ Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Do you Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol addiction	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>

Please list any medical condition not listed above.

Dental History

Reason for today's visit? _____

When was your last dental check-up? _____ Last panoramic or full set of x-rays taken? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Please check any dental problems that apply

- | | | |
|-------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> Broken or chipped teeth | <input type="checkbox"/> Sores in the mouth | <input type="checkbox"/> Denture problems |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Swelling or lumps | <input type="checkbox"/> Difficult to numb |
| <input type="checkbox"/> Hot, cold, sweet sensitivity | <input type="checkbox"/> Jaw joint pain (TMJ) | <input type="checkbox"/> Excessive bleeding after extraction or surgery? |
| <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Snoring | |

Other concerns _____

If you could improve your smile, what might you change?

- | | | |
|-----------------------------------------------|---------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Whiten teeth | <input type="checkbox"/> Straighten uneven teeth | <input type="checkbox"/> Close spaces |
| <input type="checkbox"/> Repair chipped teeth | <input type="checkbox"/> Replace old fillings or crowns | <input type="checkbox"/> Replace missing teeth |

Other concerns _____

I understand that the information I have given is correct. I authorize release of this information for medical consultation and referral, as well as insurance submission. I also understand that it is my responsibility to inform this office of any changes of my medical status.

(Signed)

(Date)