HEALTH HISTORY

	Office Use Only Yes	No
Patient's Name _____ Date of Birth _____	Pre-Med ☐	☐
Physician's Name _____ Physician's Address _____ Physician's Phone _____	Comments:	
Most recent visit to Physician _____ Reason _____		
How would you assess your general health? ☐ Good ☐ Fair ☐ Poor		

Your medications and health issues can have significant effects on your dental care. To ensure your well-being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

	Yes	No
Are you currently seeing a physician for treatment of a recent or ongoing medical condition? If yes, explain:	☐	☐
Have you been hospitalized with in the last year? If yes, explain:	☐	☐
Have you had a serious illness or operation within the last year? If yes, explain:	☐	☐
Have you ever had any serious medical trouble associated with any dental experience? If yes, explain:	☐	☐
Do you take any medications containing bisphosphonates, *e.g.*, Fosamax, Actonel, Boniva, Reclast, etc.?	☐	☐
Do you currently, or have ever taken, shots of Prolia or similar medication?	☐	☐
Do you take any weight loss medications, *e.g.*, Fen-Phen or Redux, etc.?	☐	☐
Have you ever been advised to take antibiotics (*e.g.*, penicillin, etc.) before a dental appointment? If yes, explain:	☐	☐

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Do you now or have you ever had any of the following cardiovascular diseases?
If yes, check any that apply:

☐ Heart disease	☐ Hardening of the arteries	☐ Heart attack
☐ High blood pressure	☐ Coronary bypass	☐ Stroke
☐ Angina	☐ Heart murmur	☐ Mitral valve prolapse
☐ Congestive heart failure	☐ Artificial heart valves	☐ Rhematic fever/heart disease
☐ Congenital heart defects	☐ High blood pressure	☐ High cholesterol
☐ Swelling of the ankles	☐ Shortness of breath after mild exercise	
☐ Shortness of breath when you lie down		
☐ Pacemaker. If yes, date of placement _____		

	Yes	No
Do you have diabetes? If yes, do you use insulin? Type:_____ Dose:_____	☐	☐
Do you have artificial joint(s)? If yes, which joint(s)_____	☐	☐
Do you have hepatitis?	☐	☐
Have you had a blood transfusion? If yes, when _____	☐	☐
Do you have HPV?	☐	☐
Are you HIV positive?	☐	☐
Do you have reason to suspect you have been exposed to the HIV virus?	☐	☐
Do you have Tuberculosis (TB)?	☐	☐
Have you had a TB test? If yes, when_____	☐	☐
Do you have a cough that has lasted more than three weeks?	☐	☐
Do you cough up blood?	☐	☐
Do you consider yourself currently under an abnormally high amount of stress?	☐	☐
Have you had unexplained or unplanned weight loss recently?	☐	☐
Are you on a special diet?	☐	☐

If yes, check type:

☐ Type A	☐ Other
☐ Type B	☐ Non-specific type
☐ Type C	☐ Don't know

When was your last complete physical exam with your physician,
including blood tests? _____

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Check any that apply:

☐ Allergies	☐ Alzheimer's	☐ Anemia
☐ Angina	☐ Asthma	☐ Arthritis
☐ Autoimmune	☐ Blood Disorder	☐ Cancer
☐ Chemotherapy	☐ Chronic Sinus	☐ Cirrhosis
☐ Depression	☐ Epilepsy	☐ Fainting/Dizzy Spells
☐ Glaucoma	☐ Heart Disease	☐ Herpes
☐ HIV/AIDS	☐ Hypoglycemia	☐ Jaundice
☐ Joint Replacement	☐ Kidney Disease	☐ Organ Transplant
☐ Osteoporosis	☐ Parkinson's	☐ Radiation Treatment
☐ Severe Headaches		

	Yes	No
Do you now or have you ever smoked? If yes, how much? _____	☐	☐
If you were a smoker, when did you quit? _____		
Do you chew tobacco? If yes, how often? _____	☐	☐
Do you drink alcohol?	☐	☐

WOMEN ONLY:

Are you currently pregnant?	☐	☐
Do you have regular gynecological checkups?	☐	☐
Have you reached menopause?	☐	☐
Are you on hormone replacement therapy?	☐	☐
Have you had a mammogram? If yes, when _____	☐	☐

If you <u>currently</u> take these medications, check the box on the <u>left side</u>.
If you have taken any of these medications within the <u>past year</u>, but are <u>not</u> taking them currently, check the box on the <u>right side</u>. Please list the medications.

		<u>Medication & Dosage</u>
☐ Antibiotics	☐	_____
☐ Antidepressants (Prozac, Zoloft, etc.)	☐	_____
☐ Antihistamines	☐	_____
☐ Blood pressure medication	☐	_____
☐ Blood thinners	☐	_____
☐ Cortisone (Prednisone)	☐	_____

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- ☐ Cholesterol medication
- ☐ Decongestants
- ☐ Diuretics (water pills)
- ☐ Hormones (birth control, estrogen)
- ☐ Inhalants
- ☐ Insulin
- ☐ Heart medication/nitroglycerine
- ☐ Muscle relaxants
- ☐ Pain medication (Aspirin, Advil, Tylenol, etc.)
- ☐ Sleeping pills
- ☐ Thyroid medication
- ☐ Tranquilizers

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Are you ALLERGIC (hives, rash, trouble breathing) to any of the following:

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Local dental anesthetics (Novocain)
- ☐ Tranquilizers
- ☐ Antibiotics (penicillin/tetracycline/sulfa)
- ☐ Barbiturates or sedatives
- ☐ Latex
- ☐ Metal
- ☐ Others _____
  _____
  _____

	Yes	No
Have you ever had an adverse reaction (nausea, dizziness) with any drug or medication?	☐	☐
If yes, explain: _____		
Do you have any disease, condition or medical problem not listed?	☐	☐
If yes, explain: _____		

Please list all medications and dosages you are currently taking that are not already listed above. This includes vitamins and oral contraceptives.

_____ _____ _____
_____ _____ _____
_____ _____ _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my (or patient's) medical status.

Date: _____ Signature: _____
Patient, Parent, or Guardian

Patient's Name: _____
Date of Birth: _____

DENTAL HEALTH HISTORY

Please answer the following questions in detail to ensure your well-being while undergoing treatment in our office. All information will be considered confidential and for our records only.

How often do you brush? _____

How often do you floss? _____

	Yes	No
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you wear or want dentures?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Does your jaw get stuck open or closed?	☐	☐
Do you have any jaw symptoms or headaches upon waking in the morning?	☐	☐
Does your jaw click?	☐	☐
Do you clench or grind your teeth frequently?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Do you have trouble lining up your teeth?	☐	☐
Do you have trouble biting the same way twice?	☐	☐
Do you have an oral appliance? If yes, what is it and how long have you had it? _____	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐

Patient's Name: _____
Date of Birth: _____

	Yes	No
Have you ever noticed slow healing in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sour foods?	☐	☐
Sweet foods?	☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my (or patient's) medical status.

Date: _____ Signature: _____
Patient, Parent, or Guardian