HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ Date:_____

Are you currently under the care of a physician? ☐ Yes ☐ No Physician's name: _____

Do you take a pre-medication prior to dental appointments? ☐ Yes ☐ No

Have you ever responded adversely to dental/medical treatment? ☐ Yes ☐ No

Have you ever had any of the following? (check all boxes that apply):

☐ ADD/ADHD
☐ Allergies
☐ Arthritis
☐ Artificial Heart Valves
☐ Artificial Joints, screws, etc.
☐ Asthma
☐ Back Problems (chronic pain)
☐ Bariatric Surgery
☐ Bleeding Abnormalities
☐ Blood Disease
☐ Cancer/Chemotherapy/Radiation
☐ Crohn's Disease
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Depression
☐ Diabetes
☐ Drug or Alcohol Addiction
☐ Epilepsy
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis, Jaundice or Liver Disease
☐ High Blood Pressure
☐ HIV/AIDS
☐ Hypoglycemia
☐ Kidney/Renal Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Panic Attacks
☐ Psychiatric Care
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Sinus Problems
☐ Sexually Transmitted Disease
☐ Stroke
☐ Stomach Ulcers
☐ Swollen Lymph Nodes
☐ Thyroid Disease
☐ Tuberculosis
☐ Other_____

Do you have any ALLERGIES (including latex and food)? ☐ Yes (please list below) ☐ No

_____
_____
_____
_____
_____
_____

Are you taking any medications at this time (including vitamins and over the counter medications)? ☐ Yes (please list below) ☐ No

_____
_____
_____
_____
_____
_____

Have you ever taken any of the group of drugs known as bisphosphonates? (These include Zometa (zolendronate), Actonel (risedronate), Fosamax (alendronate), Boniva (abondronate), Nerixia (neridronate), Aredia (pamidronate)) ☐ Yes ☐ No

Do you currently use tobacco? ☐ Yes ☐ No
(if checked yes above) Type: _____ How often: _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due Date _____

Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

(Child) What is his/her weight? _____

Is there anything we should know about your health that would assist us in providing your dental care? _____

_____

DENTAL HISTORY

Have you ever had any serious trouble associated with previous dental treatment? □ Yes (please explain) □ No

_____

_____

Does dental treatment make you nervous? □ No □ Slightly □ Moderately □ Extremely

Date of last dental visit: _____

Have you ever been treated for periodontal disease (gum disease)? _____

If so, when? _____

Do you have or have you ever had any of the following? (check all that apply)

□ Bleeding, sore gums	□ Unpleasant taste/bad breath	□ Burning tongue/lips
□ Frequent blisters	□ Swelling/lumps in mouth	□ Orthodontic treatment (braces)
□ Biting cheeks/lips	□ Clicking/popping jaw	□ Difficulty opening or closing jaw
□ Loose teeth	□ Sensitivity to hot/cold	□ Sensitivity to biting/chewing
□ Sensitivity to sweets	□ Food impaction	□ Clenching/grinding
□ Shifting of teeth	□ Change in bite	□ Whitening of teeth

How often do you do the following?

Brush: _____ Floss _____ Rinse _____

Is there anything about your smile that you would like to improve? _____

_____

CERTIFICATION

The information given about my health and dental histories on this form is accurate to the best of my knowledge. I hereby give my consent to perform necessary diagnostic tests (including x-rays) and evaluation of my dental health. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of patient, parent, or guardian Date

_____ _____

Printed name of parent of guardian Relationship to patient