Health History

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

A Dental History

1. Reason for visit today? _____ Apprx. date of last dental visit _____

	YES	NO
2. Do your gums bleed while brushing or flossing?	☐	☐
3. Are your teeth sensitive to hot, cold, sweet or sour liquids/foods?	☐	☐
4. Does food tend to become caught between your teeth?	☐	☐
5. Have you noticed any loosening of your teeth?	☐	☐
6. Have you ever had radiation treatment to the head or neck?	☐	☐
7. Do you have any sores or lumps in or near your mouth?	☐	☐
8. Have you had any head, neck or jaw injuries?	☐	☐
9. Do you have frequent headaches?	☐	☐
10. Do you clench or grind your teeth?	☐	☐
11. Do you bite your lips or cheeks frequently?	☐	☐

	YES	NO
12. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	☐	☐
b. Pain (joint, ear, side of face)?	☐	☐
c. Difficulty in opening or closing?	☐	☐
d. Difficulty in chewing?	☐	☐
13. Have you had any orthodontic (braces) treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
15. Have you ever had an upsetting dental experience?	☐	☐

If yes, please explain. _____

_____

16. Do you like your smile?	☐	☐

If no, please explain. _____

_____

B Medical History

	YES	NO
1. Are you under medical treatment now?	☐	☐

If yes, please explain: _____

_____

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐

If yes, please explain: _____

_____

3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

Please list: _____

_____

4. Have you ever taken Fosamax, Actonel or any cancer medication containing bisphosphonates?	☐	☐
5. Do you bruise easily?	☐	☐
6. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐

	YES	NO
7. Do you take Cialis or similar medication?	☐	☐
If yes, have you taken it in the last 24 hours?	☐	☐
8. Do you use tobacco, including smokeless tobacco?	☐	☐
9. Do you use alcohol?	☐	☐
10. Do you use controlled substances?	☐	☐
11. Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐
12. Are you wearing contact lenses?	☐	☐

Women Only:

1. Are you pregnant or think you may be pregnant?	☐	☐
2. Are you nursing?	☐	☐
3. Are you taking birth control pills?	☐	☐

(OVER)

C Medical History Continued...

	YES	NO
Are you allergic to or have you had reactions to:		
1. Local anesthetics like novocaine?	☐	☐
2. Penicillin or other antibiotics?	☐	☐
Specify_____		
3. Sulfa drugs?	☐	☐
4. Barbiturates, sedatives or sleeping pills?	☐	☐
5. Aspirin?	☐	☐
6. Iodine?	☐	☐
7. Any Metals (e.g. nickel, steel, etc.)?	☐	☐
8. Latex?	☐	☐
9. Other?_____	☐	☐
Do you have or have you ever had the following (please circle what applies):		
1. High or Low Blood Pressure	☐	☐
2. Heart Condition, Heart Disease or Heart Attack	☐	☐
3. Rheumatic Fever	☐	☐
4. Heart Defect or Murmur	☐	☐
5. Pacemaker or Artificial Heart Valves	☐	☐
6. Stroke	☐	☐

	YES	NO
7. Epilepsy or Seizures	☐	☐
8. Diabetes	☐	☐
9. Kidney Disease	☐	☐
10. HIV Infection	☐	☐
11 Thyroid Problems	☐	☐
12 Cancer	☐	☐
13. Radiation Therapy	☐	☐
14. Anemia	☐	☐
15. Joint Replacement or Implants	☐	☐
16. Hepatitis or Liver Disease	☐	☐
17. GERD	☐	☐
18. Sinus Trouble	☐	☐
19. Asthma or Allergies	☐	☐
20. Tuberculosis	☐	☐
21. Respiratory Problems/Disease	☐	☐

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 medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

For Completion By The Dentist:

SUMMARY OF DENTAL HISTORY

_____

_____

_____

_____

SUMMARY OF MEDICAL HISTORY

_____

_____

_____

MEDICAL HISTORY UPDATE:

DATE	COMMENTS	INITIALS: PATIENT	DENTIST	HYGIENIST