HEALTH INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Date: _____ Birth date _____

If minor, parents names _____ Home phone _____ Work phone _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (**Please check any that apply**)

- ❑ Abnormal Bleeding
- ❑ AIDS/HIV
- ❑ Alcohol/Drug Abuse
- ❑ Allergies or hives
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Bones /Joints/Valves
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis/Intestinal Problems
- ❑ Cardiovascular Disease
- ❑ Angina
- ❑ Bypass/Heart Surgery
- ❑ Congenital Heart Defect
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Irregular/Rapid Heartbeat
- ❑ Pacemaker/Defibrillator
- ❑ Prosthetic (Artificial) Hearth
- ❑ Valve
- ❑ Difficulty Breathing
- ❑ Depression/Anxiety
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy/Seizures
- ❑ Fainting
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Hemophilia
- ❑ Hepatitis/Jaundice
- ❑ Herpes/Fever Blisters
- ❑ Head Injury
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hospitalized for any Reason
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Organ Transplant
- ❑ Neurologic condition
- ❑ Psychiatric Treatment
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic/Scarlet Fever
- ❑ Stroke
- ❑ Shingles
- ❑ Sickle Cell Disease/Traits
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Swelling of Feet/Ankles
- ❑ Thyroid Problems
- ❑ Tuberculosis/other lung problems
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Erythromycin
- ❑ Iodine
- ❑ Metals
- ❑ Tetracycline
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Bisphosphonates
- ❑ Other:_____

Do you smoke or use chewing tobacco?
☐ Yes ☐ No

For Women Only:
Are you taking hormones or contraceptives?
☐ Yes ☐ No
Are you Pregnant?
☐ Yes ☐ No Week #:
Are you Nursing?
☐ Yes ☐ No

Do you have any disease, condition, or problem not listed above?_____

Are you currently under Medical treatment? If yes, please explain: _____

Name of your physician:_____ Phone: _____

Have you ever had any serious illnesses/operations/admitted to hospital? _____

Please list any medications you are currently taking: _____

Please add anything else you would like us to know about:_____

DENTAL HEALTH HISTORY

Are you currently in pain? _____

Do you require Antibiotic before dental procedure? _____

Have you ever had a serious/difficult problem associated with any previous dental work? _____

If yes, please explain: _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

How often do you floss? _____

How often do you brush? _____

Do you like your smile? _____

Date of last dental visit: _____

Date of last X-Rays: _____

Please check all that apply:

- ❑ Bad Breath
- ❑ Bleeding Gum
- ❑ Blister on Lips/Mouth
- ❑ Finger Nail Biting
- ❑ Grinding of Teeth
- ❑ Lip or Cheek Biting
- ❑ Loose Teeth or Broken Fillings
- ❑ Orthodontic Treatment
- ❑ Pain around Ear
- ❑ Periodontal Treatment
- ❑ Sensitivity to Cold
- ❑ Sensitivity to Hot
- ❑ Sensitivity to sweet
- ❑ Sensitivity when Biting
- ❑ Frequent Headache
- ❑ Jaw, Head Injuries
- ❑ Jaw Difficulty Clicking
- ❑ Tooth Pain

All of the preceding answers and information provided are true and correct to the best of my knowledge. If I ever have any change in my health, I will inform the doctors.

Signature of patient (or parent) _____ Date _____