HEALTH HISTORY

PATIENT'S NAME: _____ **DATE** _____

In our office we like to treat people and not just teeth! We would like to give you dental care tailored to your individual needs and ask that you aid us in answering the following questions as completely as possible. Please remember that all of your records are held in strict confidence, and cannot be released to anyone without your written notice.

DENTAL HISTORY

Tell us what we can do for you today _____

Date of last dental visit: _____ Last cleaning: _____ Last x-rays: _____

Name of former dentist: _____ Phone number: _____

What did you like and not like about your previous dental care: _____

Have you ever had a bad experience at the dentist? _____

Is there anything that concerns you about your mouth/gums/teeth/smile? _____

What could we do to give you perfect dental visits: _____

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

Do you have any of the following:

	Y	N		Y	N
Bad breath	○	○	Clicking / Popping of jaw	○	○
Bleeding / sore gums	○	○	Sensitivity to hot / cold	○	○
Loose teeth	○	○	Sensitivity to sweets	○	○
Dry mouth	○	○	Sensitivity when biting	○	○
Wisdom teeth removed	○	○	Periodontal treatment / Gum treatment	○	○
Blisters / Canker sores	○	○	Orthodontic treatment	○	○
Discolorations in mouth	○	○	Jaw Surgery / Tooth removal	○	○
Grinding / Clenching of teeth	○	○	Dental Implants	○	○

DRUG ALLERGIES

Do you have reactions or allergies to any of the following:

	Y	N		Y	N
Codiene	○	○	Dental anesthetic (novacaine, etc…)	○	○
Barbituates	○	○	Nitrous oxide (laughing gas)	○	○
Penicillin	○	○	Latex	○	○
Erythromycin	○	○	Others _____	○	○
Sulfa Drugs	○	○	_____	○	○
Aspirin	○	○			

MEDICATIONS

Please list any prescription or non prescription medication you currently take (or are supposed to be taking), dosage, and for what condition:

Medication	Dosage	Medication	Dosage

Have you taken Cortisone or any other steroids in the past 12 months?

Recreational drugs can also interfere with your dental health and anesthetics we may use during your treatment. Please inform us before treatment if any have been used within a week of your appointments.

MEDICAL HISTORY

Do you have or have you had any of the following:

	Y	N		Y	N
Heart disease / failure / attack	○	○	Hepatitis (Type)	○	○
Angina pectoris / chest pains	○	○	Liver disease / cirrhosis / jaundice	○	○
Pacemaker / defibrillator	○	○	Stomach problems / ulcers	○	○
High / low blood pressure	○	○	Sinus trouble	○	○
Rheumatic fever	○	○	Breathing difficulties	○	○
Congenital heart defect / murmur	○	○	Asthma / emphysema	○	○
Artificial heart valve..(Year replaced)	○	○	Tuberculosis	○	○
Mitral valve prolapse/heart murmur	○	○	Arthritis	○	○
Stroke / aneurysm	○	○	Artificial joint (hip, knee, etc)…(Year replaced)	○	○
Other heart problem	○	○	Diabetes…….……(Type	○	○
Blood transfusion (Date)	○	○	Thryoid disease	○	○
Anemia / Sickle cell disease	○	○	Kidney problems / failure / dialysis……..	○	○
Abnormal bleeding or healing	○	○	Drug / alcohol addiction	○	○
Fainting / dizzy spells	○	○	Cancer / tumor.....(Type /Year)	○	○
Severe headaches	○	○	Radiation / x-ray treatment	○	○
Epilepsy / seizures / convulsions	○	○	Chemotherapy	○	○
HIV positive / AIDS	○	○	Autoimmune disorder (MS, Lupus, etc)	○	○
Possible exposure to communicable diseases	○	○	Frequent nose bleeds	○	○
Veneral disease / STD	○	○	WOMEN: Are you pregnant or nursing	○	○
Transplant.....(Type /Year)	○	○	Do you use tobacco products?…….…(Type	○	○
Glaucoma	○	○			

Have you had any operations, surgery or been hospitalized?

Do you have any other condition that would be of value to know:

Name of family physician: Phone number:

Date of last visit with physician:

Dentist's comments:

PATIENT'S SIGNATURE **DATE**

DENTIST'S SIGNATURE **DATE**

Medical updates: Date Date Date Date Date