Health History

Getting to know you as our Patient

Dentist History

FULL NAME DATE OF BIRTH

WHY HAVE YOU COME TO SEE US TODAY (E.G. PAIN, CHECKUP)?

PREVIOUS DENTIST LAST VISIT LAST CLEANING

REASON FOR CHANGING DENTIST

ARE YOU NERVOUS ABOUT SEEING A DENTIST? ☐ YES! ☐ NO IF YES, WHY?

Dental and Medical Health

HOW OFTEN DO YOU BRUSH A DAY? HOW OFTEN DO YOU FLOSS?

PLEASE ANSWER THE FOLLOWING WITH A YES OR NO

☐ YES ☐ NO I CLENCH MY TEETH IN THE DAY OR WHILE SLEEPING
☐ YES ☐ NO MY GUMS BLEED WHILE BRUSHING OR FLOSSING
☐ YES ☐ NO I AVOID BRUSHING PART OF MY MOUTH DUE TO PAIN
☐ YES ☐ NO I FREQUENTLY GET FOOD TRAPPED IN MY TEETH
☐ YES ☐ NO I WANT MY TEETH WHITER
☐ YES ☐ NO MY GUMS FEEL TENDER OR SWOLLEN
☐ YES ☐ NO I HAVE PROBLEMS CHEWING
☐ YES ☐ NO I HAVE HAD ORTHONDONTIC TREATMENT
☐ YES ☐ NO I WANT MY TEETH STRAIGHTER
☐ YES ☐ NO I HAVE HAD A FACIAL OR JAW INJURY

WHAT IS YOUR HIGHEST DENTAL PRIORITY ☐ APPEARANCE ☐ HEALTH ☐ PAIN ☐ FINANCES ☐ OTHER:

I CONSIDER MY HEALTH TO BE ☐ **EXCELLENT** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

HIGH BLOOD PRESSURE	☐ YES ☐ NO	SINUS TROUBLE	☐ YES ☐ NO	CANCER/CHEMOTHERAPY	☐ YES ☐ NO
HEART DISEASE	☐ YES ☐ NO	EPILEPSY/SEIZURES	☐ YES ☐ NO	RADIATION THERAPY	☐ YES ☐ NO
HEART MURMUR	☐ YES ☐ NO	ULCERS	☐ YES ☐ NO	HISTORY OF DRUG/ALCOHOL ADDICTION	☐ YES ☐ NO
STROKE	☐ YES ☐ NO	ARTIFICIAL JOINT: HIP	☐ YES ☐ NO	AIDS/HIV	☐ YES ☐ NO
CONGENITAL HEART LESION	☐ YES ☐ NO	ARTIFICIAL JOINTS: KNEE	☐ YES ☐ NO	IMMUNE SUPPRESSED DISORDER	☐ YES ☐ NO
RHEUMATIC FEVER	☐ YES ☐ NO	LIVER DISEASE	☐ YES ☐ NO	HEARING LOSS	☐ YES ☐ NO
LOW BLOOD PRESSURE	☐ YES ☐ NO	HEPATITIS	☐ YES ☐ NO	FAINTING OR DIZZY SPELLS	☐ YES ☐ NO
ANEMIA	☐ YES ☐ NO	DIABETES	☐ YES ☐ NO	GLAUCOMA	☐ YES ☐ NO
BLEEDING DISORDER	☐ YES ☐ NO	HERPES	☐ YES ☐ NO	EMOTIONAL OR ANXIETY DISORDER	☐ YES ☐ NO
TUBERCULOSIS OR LUNG DISEASE	☐ YES ☐ NO	ARTHRITIS	☐ YES ☐ NO	TAKEN FEN-PHEN OR REDUX?	☐ YES ☐ NO
ASTHMA	☐ YES ☐ NO	SEXUAL TRANSMITTED DISEASE	☐ YES ☐ NO	EMPHYSEMA	☐ YES ☐ NO
HAY FEVER	☐ YES ☐ NO	KIDNEY DISEASE	☐ YES ☐ NO	TAKING BIRTH CONTROL MEDICATION	☐ YES ☐ NO
THYROID PROBLEMS	☐ YES ☐ NO	TUMOR OR MALIGNANCY	☐ YES ☐ NO	CURRENTLY PREGNANT	☐ YES ☐ NO
TAKEN FOSAMAX	☐ YES ☐ NO	H1N1	☐ YES ☐ NO	CURRENTLY NURSING	☐ YES ☐ NO

☐ YES ☐ NO DO YOU SMOKE OR USE TOBACCO? HOW MUCH PER DAY?_____ HOW MANY YEARS ?_____

☐ YES ☐ NO HAVE YOU HAD MAJOR SURGERY? TYPE OF OPERATION?_____ YEAR?_____

TYPE OF OPERATION?_____ YEAR?_____

Doctor Notes:

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

ASPRIN	☐ YES ☐ NO	CODEINE	☐ YES ☐ NO
IBUPROFEN	☐ YES ☐ NO	LATEX	☐ YES ☐ NO
SULFA DRUGS	☐ YES ☐ NO	PLASTICS	☐ YES ☐ NO
PENICILLIN	☐ YES ☐ NO	LOCAL ANESTHESIA	☐ YES ☐ NO
OTHER	☐ YES ☐ NO		

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____

☐ **YES** ☐ **NO** **DO YOU HAVE ANY OTHER MEDICAL PROBLEM OR HISTORY NOT LISTED ON THIS FORM? PLEASE EXPLAIN:**

I certify that I read the above conditions and agree to their content. All information provided is accurate to the best of my knowledge.

SIGNATURE _____ **DATE**_____

Initial Doctor Review _____ Date_____

Health History and Medical Update: Do not Complete until Next Visit

☐ YES ☐ NO THERE HAVE BEEN CHANGES TO MY HEALTH HISTORY or ADDRESS. IF YES, PLEASE MARK CHANGES ABOVE. INITIALS _____DATE _____

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