Health History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering all the following questions.

Patient Name_____ **Date of Birth**_____

Dental History

Yes / No Do you have a specific dental problem? If yes, please explain _____
Yes / No Do your gums ever bleed? _____
Yes / No Does food catch between your teeth? _____
Yes / No Do you have any loose teeth? _____
Yes / No Do you ever have clicking, popping or discomfort in your jaw joint? _____
Yes / No Do you clench or grind your teeth? _____
Yes / No Do you smoke or chew tobacco? _____
Yes / No Do you have any growths or sores in your mouth? _____
Yes / No Do you require pre-medication prior to dental appointments? _____

Date of last dental visit_____ Previous Dentist's name_____
Date of last full set of x-rays (18 films or panoramic)_____ How often do you brush and floss?_____

Medical History

Yes / No Are you under the care of a physician? For what?_____ Physician's name_____ Phone_____
Yes / No Have you ever been hospitalized or had a major operation? If yes, please explain_____
Yes / No Have you ever had a serious injury to your head or neck? If yes, please explain_____
Yes / No Are you taking any medications, drugs or supplements? Please list _____
Yes / No Have you ever taken the medication Phen-Fen or Redux? _____
Yes / No Do you take, or have you ever taken Bisphosphonates for Osteoporosis? _____
Yes / No Are you on a special diet? _____
Yes / No Are you allergic to any medications or substances? If yes, please circle below: _____
Aspirin Penicillin Codeine Acrylic Metals Latex Rubber Other:_____

Women: *Are you pregnant or trying to get pregnant?* ***Yes / No*** *Nursing?* ***Yes / No*** *Taking Oral Contraceptives?* ***Yes / No***

Do you have, or have you had, any of the following?

Yes / No	Heart trouble/Disease	**Yes / No**	Breathing Problem	**Yes / No**	Kidney Problems
Yes / No	Heart Murmur	**Yes / No**	Shortness of Breath	**Yes / No**	Renal Dialysis
Yes / No	Irregular Heart Beat	**Yes / No**	Frequent Cough	**Yes / No**	Thyroid Disease
Yes / No	Angina/Chest Pain	**Yes / No**	Hay Fever	**Yes / No**	Parathyroid Disease
Yes / No	Heart Attack/Failure	**Yes / No**	Sinus Trouble	**Yes / No**	Arthritis or Gout
Yes / No	Congenital Heart Disorder	**Yes / No**	Asthma	**Yes / No**	Rheumatism
Yes / No	Mitral Valve Prolapse	**Yes / No**	Bloody Sputum	**Yes / No**	Cortisone Medicine
Yes / No	Scarlet Fever	**Yes / No**	Emphysema	**Yes / No**	Artificial Joint/Joint Replacement
Yes / No	Rheumatic Fever	**Yes / No**	Tuberculosis	**Yes / No**	Venereal Disease
Yes / No	Bacterial Endocarditis	**Yes / No**	Cancer	**Yes / No**	AIDS
Yes / No	Artificial Heart Valve	**Yes / No**	Radiation Treatments	**Yes / No**	HIV Positive
Yes / No	Heart Pace Maker	**Yes / No**	Chemotherapy	**Yes / No**	Genital Herpes
Yes / No	Blood Disease	**Yes / No**	Stomach/Intestinal Disease	**Yes / No**	Drug Addiction/Alcoholism
Yes / No	High Blood Pressure	**Yes / No**	Ulcers	**Yes / No**	Tattoos
Yes / No	Heart Surgery	**Yes / No**	Recent Weight Loss	**Yes / No**	Cold Sores/Fever Blisters/Herpes
Yes / No	Unexplained Fever	**Yes / No**	Frequent Diarrhea	**Yes / No**	Stroke
Yes / No	Bruise Easily	**Yes / No**	Diabetes	**Yes / No**	Convulsions or Epilepsy
Yes / No	Anemia	**Yes / No**	Excessive Thirst	**Yes / No**	Fainting or Dizziness
Yes / No	Excessive Bleeding	**Yes / No**	Hypoglycemia	**Yes / No**	Glaucoma
Yes / No	Sickle Cell Disease	**Yes / No**	Liver Disease	**Yes / No**	Tumors or Growths
Yes / No	Hemophilia (Blood Condition)	**Yes / No**	Hepatitis A (Infectious)	**Yes / No**	Dental Anxiety
Yes / No	Leukemia	**Yes / No**	Hepatitis B	**Yes / No**	Psychiatric Care
Yes / No	Blood Transfusion	**Yes / No**	Hepatitis C	**Yes / No**	Alzheimer's Disease
Yes / No	Swelling of the Limbs	**Yes / No**	Night Sweats	**Yes / No**	Allergies (Pollen/Dust)
Yes / No	Lung Disease	**Yes / No**	Yellow Jaundice	**Yes / No**	Hives or Rash

Yes / No Do you have any other illness/condition not listed above?_____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at my next appointment without fail.

Patient/Guardian Signature:_____ **Today's Date:**_____
Comments:_____BP:_____
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