HEALTH HISTORY

Patient Name: _____ How do you wish to be addressed: _____
General Information (For our records only and will be kept confidential):

Physician name: _____ Date of last physical exam: _____

Name of previous dentist:_____ Date of last dental exam:_____

Date and type of last dental x-rays (if known):_____
CIRCLE:

YES NO 1. Are you having pain or discomfort at this time? _____
YES NO 2. Do you feel nervous about having dental treatment?_____
YES NO 3. Have you ever had a bad experience in a dental office? _____
YES NO 4. Have you been a patient in the hospital during the last two years? _____
YES NO 5. Have you been under the care of a medical doctor during the last two years? _____
YES NO 6. Have you taken any medicines or drugs in the last two years? If yes, which ones? _____
_____
YES NO 7. Are you taking any vitamins, herbal supplements, or "cures"? _____
YES NO 8. Are you allergic to (i.e. hives, rash, itching, difficulty breathing) any medicines? If so, which ones? ___
_____
YES NO 9. Are you intolerant to any medicines (upset stomach, ringing in ears, nausea, vomiting?) If so, which ones?
_____
YES NO 10. WOMEN: Are you pregnant? _____

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH APPLY TO YOUR PRESENT OR PAST HEALTH

Heart Failure	Ulcers	Alcoholism	Herpes
Heart Disease or Failure	Mental Retardation	Cortisone Medicine	Seizures/Epilepsy
Angina Pectoris	Emphysema	Glaucoma	Fainting or Dizzy
High Blood Pressure	Cough (>10 days)	Pain in Jaw Joints	Any Type of Implant**
Heart Murmur**	Tuberculosis (TB)	Birth Defects	(heart valve, knee, joint, etc)
Rheumatic Fever	Asthma	HIV Positive, ARC, AIDS	Psychiatric Treatment
Congenital Heart Lesions	Hay Fever	Hepatitis A	Sickle Cell Disease
Use of Tobacco Products	Sinus Trouble	Hepatitis B	Bruise Easily
Thyroid Disease	Allergies or Hives	Hepatitis C	Liver Disease
Heart Pacemaker/ICD	Diabetes	Jaundice	Artificial Hip/Knee
Or other			
Sexually Transmitted Disease	Heart Surgery	Blood Transfusion	Drug Addiction
Cancer (type) _____	Radiation Therapy	Hemophilia	Anemia
Chemotherapy	Any Type of Transplant**	Kidney Trouble	Arthritis
Cold Sores	Any other condition not listed: _____		

**for these conditions only, is antibiotic pre-medication required prior to your dental appointment? _____

CIRCLE

YES NO 11. Have you ever had oral hygiene instructions (brushing/flossing your teeth)? _____
YES NO 12. Are there any growths or sores in or around your mouth? _____
YES NO 13. Do you have any trouble chewing? _____
YES NO 14. Does food catch between your teeth? _____
YES NO 15. Do you have pain in or near your ears? _____
YES NO 16. Do you habitually clench or grind your teeth during the day or night? _____
YES NO 17. Have you ever been told that you have "gum problems"? _____
YES NO 18. Do you now have bleeding gums or any other gum condition? _____
YES NO 19. is there anything you dislike about your smile? _____

Signature: _____ Date: _____