HEALTH HISTORY

PATIENT NAME ______________________________ **DATE** ______________

Primary reason for this dental appointment: ❑ Examination ❑ Emergency ❑ Consultation

DENTAL HISTORY **Please Circle**

Do you have a specific dental problem? Describe ______	Yes	No
Do you have dental examinations on a routine basis? Last visit ______	Yes	No
Do you think you have active decay or gum disease? ______	Yes	No
Do you brush and floss on a routine basis? Discuss ______	Yes	No
Do your gums ever bleed? Discuss ______	Yes	No
Do you like your smile? Why? ______	Yes	No
Does food catch between your teeth? Any loose teeth? ______	Yes	No
Do you want to keep your remaining teeth? ______	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ______	Yes	No
Have your past experiences in a dental office always been positive? ______	Yes	No
Do you smoke or chew? Any sores or growths in your mouth? Discuss ______	Yes	No
Name of previous dentist (optional): ______		
Date of last full mouth x-rays (16 small films or panocramic): ______		

MEDICAL HISTORY

Are you under a physician's care now? Why? ______ Who? ______ Phone ______	Yes	No
Have you ever been hospitalized or had a major operation? Discuss ______	Yes	No
Have you ever had a serious injury to your head or neck? Discuss ______	Yes	No
Are you taking any medications, pills or drugs? What? ______	Yes	No
Are you on a special diet? Discuss ______	Yes	No
Are you allergic to any medications or substances? Please check box below	Yes	No
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Other ______		
Women (*Please check*): ❑ Pregnant/trying to get pregnant ❑ Nursing ❑ Taking oral contraceptives Discuss ______	Yes	No

Do you now have or have you ever had the following? Please check appropriate boxes
If yes to any of the starred conditions, please call prior to your appointment…premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease Surgery*	❑	❑	Bruise Easily/Blood Disease	❑	❑	Emphysema	❑	❑	Yellow Jaundice	❑	❑	Cold Sores	❑	❑
Heart Murmur*	❑	❑	Anemia	❑	❑	Tuberculosis	❑	❑	Kidney Problems	❑	❑	Fever Blisters	❑	❑
Irregular Heart Beat	❑	❑	Excessive Bleeding	❑	❑	Cancer	❑	❑	Renal Dialysis	❑	❑	Herpe	❑	❑
Angina/Chest Pain	❑	❑	Hemophilia (Bleeding Problem)	❑	❑	Chemotherapy	❑	❑	Parathyroid Disease	❑	❑	Convulsions	❑	❑
Congenital Heart Disorder	❑	❑	Leukemia	❑	❑	Stomach/Intestinal Disease	❑	❑	Arthritis/Gout	❑	❑	Epilepsy or Seizures	❑	❑
Mitral Valve Prolapse*	❑	❑	Recent Blood Transfusion	❑	❑	Ulcers	❑	❑	Rheumatism	❑	❑	Fainting or Dizziness	❑	❑
Scarlet Fever	❑	❑	Swelling of Limbs	❑	❑	Recent Weight Loss	❑	❑	Pain Jaw Joints	❑	❑	Glaucoma	❑	❑
Rheumatic Fever*	❑	❑	Lung Disease	❑	❑	Frequent Diarrhea	❑	❑	Cortisone Medicine	❑	❑	Tumors or Growths	❑	❑
Artificial Heart Valve*	❑	❑	Breathing Problem	❑	❑	Diabetes	❑	❑	Artificial Join	❑	❑	Nervousness	❑	❑
Heart Pace Maker*	❑	❑	Shortness of Breath	❑	❑	Excessive Thirst	❑	❑	Venereal Disease	❑	❑	Psychiatric Care	❑	❑
Pulmonary Shunt	❑	❑	Frequent Cough	❑	❑	Hypoglycemia	❑	❑	AIDS	❑	❑	Alzheimer's Disease	❑	❑
High Blood Pressure	❑	❑	Hay Fever	❑	❑	Liver Disease	❑	❑	HIV Positive	❑	❑	Allergies (Medicine)	❑	❑
Low Blood Pressure	❑	❑	Sinus Trouble	❑	❑	Hepatitis A (infectious)	❑	❑	Genital Herpes	❑	❑	Allergies (Pollen/Dust)	❑	❑
Bacterial Endocarditis	❑	❑	Asthma	❑	❑	Hepatitis B or C	❑	❑	Drug Addition/Alcoholism	❑	❑	Hives or Rash	❑	❑
Unexplained Fever	❑	❑	Bloody Sputum	❑	❑	Night Sweats	❑	❑	Tattoos/Body Piercing	❑	❑	Need Premedication?	❑	❑
Ever take fen-phen?	❑	❑												

Have you ever had any other serious illness not checked above? Discuss ______	Yes	No
Do you wish to talk to the dentist privately about any problem? ______	Yes	No

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 the next appointment without fail.

X ______________________________ Date ______________
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor ______________________ Date __________ BP __________ Pulse ______

History Review and Significant Findings:

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated ____________________ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.
		None ❑				Dr.