



Patient Health History

In order to help us properly render dental services to you, please answer the following questions regarding your health history. Please note the space for remarks for any answers that require clarification, or any other information you think we should have. Thank you for your cooperation.

DATE _____

NAME (Last) (First) (M.I.) HOME PHONE CELL PHONE

ADDRESS CITY STATE ZIPCODE

EMAIL DATE OF BIRTH SEX SSN TYPE OF DENTAL INSURANCE

MARITAL STATUS SPOUSE'S NAME IN CASE OF EMERGENCY, CONTACT (Specify someone not living with you.)

EMPLOYER NAME AND ADDRESS BUSINESS PHONE

REFERRED BY MOST CONVENIENT APPOINTMENT TIME

MEDICAL HISTORY

General Health (please check): EXCELLENT GOOD FAIR POOR

1. Do you have or have you had any of the following?

Mitral Valve Prolapse or heart murmur.....	NO	YES	rheumatic fever/rheumatic heart disease.....	NO	YES
Heart Disease/Heart attack.....	NO	YES	Do you have a cardiac pacemaker.....	NO	YES
Irregular heart beat.....	NO	YES	High Blood Pressure.....	NO	YES
Chest pains or angina.....	NO	YES	Stroke.....	NO	YES
Asthma or hay fever.....	NO	YES	Sinus trouble.....	NO	YES
Hepatitis/liver disease.....	NO	YES	Tuberculosis.....	NO	YES
Thyroid trouble.....	NO	YES	Kidney disease.....	NO	YES
Diabetes.....	NO	YES	Epilepsy.....	NO	YES
Anemia.....	NO	YES	Arthritis.....	NO	YES
Glaucoma.....	NO	YES	Sexually transmitted disease.....	NO	YES
Radiation or cancer therapy.....	NO	YES	HIV/AIDS or other immunosuppressive disease	NO	YES

- 2. Do you have any artificial heart valves? NO YES
- 3. Do you have a history of infective endocarditis? . NO YES (if yes please elaborate) _____
- 4. Do you have a congenital heart defect? NO YES (if yes please elaborate) _____
- 5. Do you have a cardiac transplant? NO YES

- 6. Do you have any disorder treated with oral or I.V. bisphosphonates (such as Fosamax, Boniva, or Zometa)? ... NO YES
- 7. Have you ever been hospitalized? NO YES
- 8. Have you had excessive, prolonged, or abnormal bleeding? NO YES
- 9. Are you pregnant or nursing? NO YES
Est. delivery: _____
- 10. Do you have excessive urination and/or thirst? NO YES
- 11. Are you subject to fainting spells? NO YES
- 12. Do you smoke or use smokeless tobacco? NO YES
- 13. Are you currently under the care of a physician? NO YES

When were you last seen by a physician? _____
 What is the condition being treated? _____
 Name of Physician: _____
 Address: _____
 Phone: _____

14. Are you allergic to any medications? NO YES

Check all that apply: Penicillin Codeine Aspirin Local injected anesthetics Other Medications _____

15. Do you have or have you had any disease, condition, or problem not listed here? NO YES

If so, explain _____

Are you currently taking any drugs or medications? NO YES

CURRENT MEDICATIONS (Please fill in as much information as possible)

Name	Dose/Frequency	Reason

DENTAL HEALTH

1. Reason for visit _____

2. When was your last dental visit? _____

3. Have you ever had any serious problem associated with previous dental treatment? NO YES

If so, explain _____

4. How often do you brush your teeth? _____

5. How often do you floss? _____

6. Do your gums bleed when brushing or flossing? NO YES

7. Do you avoid brushing any part of your mouth because of pain? NO YES Where? _____

8. Do you feel twinges of pain when your teeth come in contact with:

a. Hot foods or liquids, i.e., soup, coffee, tea, etc.? NO YES

b. Cold foods or liquids, i.e., ice cream, cold water, etc.? NO YES

c. Sweets, i.e., candy, fruit, sweet desserts, etc.? NO YES

9. Do you chew on only one side of your mouth NO YES

If YES, explain: _____

10. Do your gums feel tender or swollen? NO YES

11. Do you clench or grind your jaws while sleeping or during the day? NO YES

12. Do your jaws ever feel tired? NO YES

13. Do you gag easily? NO YES

14. Do you lose or break fillings? NO YES

15. Do you like the way your teeth look? NO YES

If NO, explain: _____

16. Are you familiar with the term "preventive dentistry"? NO YES

Please add anything you feel is important _____

I have reviewed the information I have provided, and to the best of my knowledge, it is correct and complete.

Patient / Guardian Signature: _____